Category III CPT Codes

Guideline Number: MPG043.39
Approval Date: March 13, 2024
Effective Date: May 1, 2024

Terms and Conditions

Table of Contents **Page**

Related Policies

See References

Policy Summary

See Purpose

Overview

The American Medical Association (AMA) develops temporary Current Procedural Terminology (CPT) Category III codes to track the utilization of emerging technologies, services, and procedures. The Category III CPT code description does not establish a service or procedure as safe, effective or applicable to the clinical practice of medicine.

Guidelines

Section 1862(a)(1)(A) of the Social Security Act is the basis for denying payment for types of care, items, services, and procedures, not excluded by any other statutory clause while meeting all tec0hnical requirements for coverage, that are determined to be any of the following:

- Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used;
- Not proven to be safe and effective based on peer review or scientific literature;
- Experimental;
- Not medically necessary for a particular patient;
- Furnished at a level, duration, or frequency that is not medically appropriate;
- Not furnished in accordance with accepted standards of medical practice; or
- Not furnished in a setting appropriate to the patient's medical needs and condition.

Items and services must be established as safe and effective to be considered medically necessary. That is, the items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment; and
- Necessary for, and consistent with, generally accepted professional medical standards of care (e.g., not experimental); and
- Not furnished primarily for the convenience of the patient, the provider or supplier; and
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational and are not considered reasonable and necessary under SSA 1862(a)(1)(A). Medicare payment, therefore, may not be made for procedures performed using devices that have not been approved for marketing by the FDA unless performed in an approved FDA Investigational Device Exemption (IDE) trial.

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure (CPT Codes 0054T and 0055T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Computer-Assisted Surgical Navigation for Musculoskeletal Procedures.

Focused Ultrasound Ablation of Uterine Leiomyomata (CPT Codes 0071T and 0072T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.

Retinal Prosthesis (CPT Code 0100T)

Medicare has determined that the Argus® II device, which is the device that is implanted for the retinal prosthesis implant procedure, is no longer available in the marketplace. Medicare also understands that both outpatient hospital providers and ASCs are no longer performing the Argus® II implantation procedure. Refer to CMS Transmittals 11472, (July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System) and 11457 July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS).

Extracorporeal Shock Wave Involving Musculoskeletal System (CPT Codes 0101T and 0102T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Extracorporeal Shock Wave Therapy (ESWT). For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds.

Quantitative Sensory Testing (QST) (CPT Codes 0106T, 0107T, 0108T, 0109T, and 0110T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Quantitative Sensory Testing (QST). For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.

Lumbar Artificial Disc Replacement (CPT Code 0165T)

Lumbar artificial disc replacement (LADR) for members over 60 years of age is not covered. Refer to the NCD for Lumbar Artificial Disc Replacement (LADR) (150.10). Medicare does not have a National Coverage Determination (NCD) for members 60 years of age and younger; coverage determination is to be made by the local contractor. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for Lumbar Artificial Disc Replacement.

Computer Aided Detection (CAD) Systems (CPT Codes 0174T and 0175T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Posterior Vertebral Joint(s) Arthroplasty (CPT Code 0202T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

Evacuation of Meibomian Glands (CPT Codes 0207T and 0563T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Automated Audiometry (CPT Codes 0208T, 0209T, 0210T, 0211T, and 0212T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Facet Joint Interventions (CPT Codes 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0219T, 0220T, 0221T, and 0222T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories. Refer to the references table for Facet Joint Interventions.

Platelet Rich Plasma (CPT Code 0232T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Platelet Rich Plasma. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prolotherapy and Platelet Rich Plasma Therapies.

Transluminal Peripheral Atherectomy (CPT Codes 0234T, 0235T, 0236T, and 0237T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Autologous Cellular Therapy (CPT Codes 0263T, 0264T, 0265T, 0489T, 0490T, 0565T, 0566T, 0717T, and 0718T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.

Carotid Sinus Baroreflex Activation Device (CPT Codes 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, and 0273T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Percutaneous Image-Guided Lumbar Decompression (PILD) (CPT Code 0275T)

CMS has determined that PILD will be covered by Medicare under section 1862(a)(1)(E) of the Social Security Act through Coverage with Evidence Development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study. Refer to the NCD Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13).

Scrambler Therapy (CPT Code 0278T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

Tear Film Imaging (CPT Code 0330T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Myocardial Sympathetic Innervation Imaging (CPT Codes 0331T and 0332T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Automated Visual Evoked Potentials (VEPs) for Visual Acuity Screening (CPT Code 0333T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Electroretinography (ERG). For coverage guidelines, for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Sinus Tarsi Implant (CPT Codes 0335T, 0510T and 0511T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Transcatheter Renal Sympathetic Denervation (CPT Codes 0338T and 0339T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Therapeutic Apheresis with Selective HDL Delipidation and Plasma Reinfusion (CPT Code 0342T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Apheresis.

Transcatheter Mitral Valve Repair (CPT Code 0345T)

Medicare covers transcatheter edge-to-edge repair (TEER) for mitral valve regurgitation under Coverage with Evidence Development (CED). Refer to the NCD Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (20.33).

Radiostereometric Analysis (RSA) (CPT Codes 0347T, 0348T, 0349T, and 0350T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Optical Coherence Tomography of Breast (CPT Codes 0351T, 0352T, 0353T, and 0354T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Bioelectrical Impedance Analysis Whole Body Composition Assessment (CPT Code 0358T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Endoscopic Retrograde Cholangiopancreatography (ERCP) with Optical Endomicroscopy (CPT Code 0397T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Cardiac Contractility Modulation (CPT Codes 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, and 0418T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Computer-Aided Tactile Breast Imaging (CPT Code 0422T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.

Percutaneous Cryoablation (CPT Codes 0440T, 0441T, and 0442T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Drug Eluting Ocular Inserts (CPT Codes 0444T and 0445T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Visual Evoked Potential Testing for Glaucoma (CPT Code 0464T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Electroretinography (ERG). For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.

Retinal Polarization Scan (CPT Codes 0469T)

This service has a Status Indicator of 'N' (Non-covered) on the National Physician Fee Schedule. This service is not covered by Medicare.

Retinal Prosthetic Device Evaluation and Programming (CPT Codes 0472T and 0473T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Transcatheter Mitral Valve Implantation/Replacement (TMVI) with Prosthetic Valve (CPT Codes 0483T and 0484T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures.

Optical Coherence Tomography (OCT) of Middle Ear (CPT Codes 0485T and 0486T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Lower Extremity Endovascular Procedures (CPT Codes 0238T and 0505T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Lower Extremity Endovascular Procedures.

Heterochromatic Flicker Photometry (CPT Code 0506T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Near-Infrared Dual Imaging of Meibomian Glands (CPT Code 0507T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Extracorporeal Shock Wave for Integumentary Wound Healing (CPT Codes 0512T and 0513T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds.

Wireless Cardiac Stimulator for Left Ventricular Pacing (CPT Codes 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0861T, 0862T, and 0863T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Intracardiac Ischemia Monitoring Systems (CPT Codes 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, and 0532T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Category III Codes. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Transapical Mitral Valve Repair (CPT Code 0543T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures.

Transcatheter Mitral Valve Annulus Reconstruction (CPT Code 0544T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures.

Transcatheter Tricuspid Valve Reconstruction, Repair, Implantation (TTVI) or Replacement (CPT Codes 0545T, 0569T, 0570T, and 0646T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures.

Three Dimensional (3D) Printed Anatomic Models (CPT Codes 0559T, 0560T, 0561T, and 0562T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Chemotherapeutic Drug Cytotoxicity Assay of Cancer Stem Cells (CSCS) (CPT Code 0564T)

Human tumor drug sensitivity assays are considered experimental, and therefore, not covered under Medicare at this time. Refer to NCD Human Tumor Stem Cell Drug Sensitivity Assays (190.7). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for In Vitro Chemosensitivity & Chemoresistance Assays.

Fallopian Tube Occlusion with a Degradable Biopolymer Implant (CPT Code 0567T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Sonosalpingography (CPT Code 0568T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Implantable Cardioverter-Defibrillator System with Substernal Electrode (CPT Codes 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, and 0580T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Cryoablation of Breast Carcinoma and Fibroadenoma (CPT Code 0581T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

High-Energy Water Vapor Thermotherapy (CPT Code 0582T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Tympanostomy (Requiring Insertion of Ventilating Tube) (CPT Code 0583T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Limb Lengthening Procedure (CPT Code 0594T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Noncontact Real-Time Fluorescence Wound Imaging (CPT Codes 0598T and 0599T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds.

Irreversible Electroporation (IRE) Ablation (CPT Codes 0600T and 0601T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Remote Monitoring of an External Continuous Pulmonary Fluid Monitoring System (CPT Codes 0607T and 0608T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Eye-Movement Analysis without Spatial Calibration (CPT Code 0615T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Iris Prosthesis Insertion (CPT Codes 0616T, 0617T, and 0618T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Percutaneous Injection of Allogeneic Cellular/Tissue-Based Products (CPT Codes 0627T, 0628T, 0629T, and 0630T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.

Hyperspectral Imaging (CPT Code 0631T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Computed Tomography of the Breast (CPT Codes 0633T, 0634T, 0635T, 0636T, 0637T, and 0638T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.

Non-contact Near-Infrared Spectroscopy (NIRS) (CPT Codes 0640T and 0859T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the references table for Noncontact Near-Infrared Spectroscopy. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Magnetic Gastropexy with Gastrostomy Tube Insertion (CPT Code 0647T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Magnetically Controlled Capsule Endoscopy (CPT Code 0651T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Transperineal Focal Laser Ablation (CPT Code 0655T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Vertebral Body Tethering (CPT Codes 0656T and 0657T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Vertebral Body Tethering for Scoliosis.

Electrical Impedance Spectroscopy for Automated Melanoma Risk Score (CPT Code 0658T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Intracoronary Infusion of Supersaturated Oxygen (CPT Code 0659T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Donor Hysterectomy (CPT Codes 0664T, 0665T, 0666T, and 0667T)

These services have a Status Indicator of 'N' (Non-covered) on the National Physician Fee Schedule. These services are not covered by Medicare.

Uterus Transplantation (CPT Codes 0668T, 0669T, and 0670T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Cryogen-Cooled Monopolar Radiofrequency (CMRF) (CPT Code 0672T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Remote, Online and/or Digital Therapy for Amblyopia (CPT Codes 0687T, 0688T, 0704T, 0705T, and 0706T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy.

Aquapheresis (Ultrafiltration) (CPT Code 0692T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Vertebral Motion Analysis (CPT Code 0693T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis.

Three-Dimensional Imaging and Reconstruction of Breast or Axillary Lymph Node Tissue (CPT Code 0694T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Electrocardiographic Body Surface Mapping (CPT Codes 0695T and 0696T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Transperineal Laser Ablation (TPLA) (CPT Code 0714T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Posterior Lumbar Vertebral Joint Replacement (CPT Code 0719T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

Percutaneous Electrical Nerve Field Stimulation (PENFS) (CPT Code 0720T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

Colonic Lavage with Insertion Of Rectal Catheter (CPT Code 0736T)

There are no conditions for which colonic irrigation is medically indicated and no evidence of therapeutic value. Accordingly, colonic irrigation cannot be considered reasonable and necessary within the meaning of section 1862(a)(1) of the Act. Refer to the NCD Colonic Irrigation (100.7).

Xenograft Implantation (CPT Code 0737T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Surgery of the Knee.

Prostate Tissue Ablation by Magnetic Field Induction (CPT Codes 0738T and 0739T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.

Bone Strength and Fracture-Risk Assessment Using Digital X-Ray Radiogrammetry-Bone Mineral Density (DXR-BMD) (CPT Codes 0749T and 0750T)

These services have a Status Indicator of 'N' (Non-covered) on the National Physician Fee Schedule. These services are not covered by Medicare.

Bioprosthetic Valve Insertion (CPT Code 0744T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins.

Transcutaneous Magnetic Stimulation (tMS) (CPT Codes 0766T, 0767T, 0768T, and 0769T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Sacroiliac Joint Arthrodesis (CPT Codes 0775T and 0809T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Sacroiliac Joint Interventions.

Surface Mechanomyography (sMMG) (CPT Code 0778T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.

Gastrointestinal Myoelectrical Activity Study (CPT Code 0779T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Gastrointestinal Motility Disorders, Diagnosis and Treatment.

Transcutaneous Auricular Neurostimulation (tAN) (CPT Code 0783T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

Silver Diamine Fluoride for Dental Caries (CPT Code 0792T)

This service has a Status Indicator of 'N' (Non-covered) on the National Physician Fee Schedule. This service is not covered by Medicare.

Leadless Pacemakers (CPT Codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 0823T, 0824T, 0825T, and 0826T)

Medicare covers leadless pacemakers through Coverage with Evidence Development (CED). Refer to NCD Leadless Pacemakers (20.8.4).

Caval Valve Implantation (CAVI) (CPT Codes 0805T and 0806T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures.

Esophagogastroduodenoscopy with Intragastric Bariatric Balloon Adjustment (CPT Code 0813T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery.

Injectable Bone Substitutes (CPT Code 0814T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Bone Healing Enhancement Products.

Transcranial Magnetic Stimulation with Concomitant Measurement of Evoked Cortical Potentials (CPT Code 0858T)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation.

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 guideline 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 the member specific benefit plan document 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 Guidelines may apply.

This list contains the following CPT codes:

- Non-Covered
- Provisional Coverage

CPT Code	Description
Non-Covered	
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving lateral humeral epicondyle
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)021
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report (Deleted 02/29/2024)
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral
0208T	Pure tone audiometry (threshold), automated; air only
0209T	Pure tone audiometry (threshold), automated; air and bone
0210T	Speech audiometry threshold, automated;
0211T	Speech audiometry threshold, automated; with speech recognition
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s)

CPT Code	Description
Non-Covered	
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
0219T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical
0220T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
0222T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel
0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta
0237T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)

CPT Code	Description
Non-Covered	
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes)
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report (Deleted 02/29/2024)
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT
0333T	Visual evoked potential, screening of visual acuity, automated, with report
0335T	Insertion of sinus tarsi implant
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred
0353T	Optical coherence tomography of breast, surgical cavity; real-time intraoperative
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)

CPT Code	Description
Non-Covered	
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator) (Deleted 12/31/2023)
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only (Deleted 12/31/2023)
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only (Deleted 12/31/2023)
0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only (Deleted 12/31/2023)
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only (Deleted 12/31/2023)
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only (Deleted 12/31/2023)
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only (Deleted 12/31/2023)
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only (Deleted 12/31/2023)
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only (Deleted 12/31/2023)
0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only (Deleted 12/31/2023)
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea (Deleted 12/31/2023)

CPT Code	Description
Non-Covered	
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session (Deleted 12/31/2023)
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study (Deleted 12/31/2023)
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication) (Deleted 12/31/2023 – See 67516)
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral
0472T	Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional
0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children (Deleted 12/31/2023)
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure) (Deleted 12/31/2023)
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g., thoracotomy, transapical)
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report

CPT Code	Description
Non-Covered	
0507T	Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0510T	Removal of sinus tarsi implant
0511T	Removal and reinsertion of sinus tarsi implant
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and/or transmitter) only
0518T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only
0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)
0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only

CPT Code	Description
Non-Covered	
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration, download review, interpretation and report (Deleted 12/31/2023 – See 95999)
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; set-up, patient training, configuration of monitor (Deleted 12/31/2023 – See 95999)
0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; data upload, analysis and initial report configuration (Deleted 12/31/2023 – See 95999)
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; download review, interpretation and report (Deleted 12/31/2023 – See 95999)
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional (Deleted 09/30/2023)
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral
0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound
0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)
0572T	Insertion of substernal implantable defibrillator electrode
0573T	Removal of substernal implantable defibrillator electrode
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode

CPT Code	Description
Non-Covered	
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results
0580T	Removal of substernal implantable defibrillator pulse generator only
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous (Deleted 12/31/2023)
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic (Deleted 12/31/2023)
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open (Deleted 12/31/2023)
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (e.g., lower extremity)
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (e.g., upper extremity) (List separately in addition to code for primary procedure)
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment

CPT Code	Description
Non-Covered	
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional
0615T	Eye-movement analysis without spatial calibration, with interpretation and report
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
0640T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site
0641T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); image acquisition only, each flap or wound (Deleted 12/31/2023 – See 0640T, 0859T)
0642T	Noncontact near-infrared spectroscopy studies of flap or wound (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); interpretation and report only, each flap or wound (Deleted 12/31/2023 – See 0640T, 0859T)
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report

CPT Code	Description
Non-Covered	
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (e.g., fluoroscopy), angiography, and radiologic supervision and interpretation
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor
0665T	Donor hysterectomy (including cold preservation); open, from living donor
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session
0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month
0692T	Therapeutic ultrafiltration
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report
0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative
0695T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement
0696T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up interrogation or programming device evaluation
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment
0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month

CPT Code	Description
Non-Covered	
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance (Effective 07/01/2022)
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs (Effective 07/01/2022)
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral (Effective 07/01/2022)
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment (Effective 07/01/2022)
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation (Effective 07/01/2022)
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter (Effective 07/01/2022)
0737T	Xenograft implantation into the articular surface (Effective 07/01/2022)
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination (Effective 01/01/2023)
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation (Effective 01/01/2023)
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density, with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and bone mineral density and classification of any vertebral fractures, with overall fracture risk assessment, interpretation and report (Effective 01/01/2023) (Deleted 12/31/2023)
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (e.g., polyester, ePTFE, bovine pericardium), when performed (Effective 01/01/2023)
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report; (Effective 01/01/2023)
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD (Effective 01/01/2023)
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve (Effective 01/01/2023)
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) (Effective 01/01/2023)
0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve (Deleted 12/31/2023 – See 0766T, 0767T)

CPT Code	Description
Non-Covered	
0769T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) (Deleted 12/31/2023 – See 0766T, 0767T)
0775T	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (e.g., bone allograft[s], synthetic device[s]) (Deleted 12/31/2023 - See 27278, 27279)
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function (Effective 01/01/2023)
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report (Effective 01/01/2023)
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment (Effective 01/01/2023)
0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional (Effective 07/01/2023)
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach (Effective 07/01/2023)
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach (Effective 07/01/2023)
0809T	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intra-articular implant(s), including allograft or synthetic device(s) (Deleted 12/31/2023 - See 27278, 27279)
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon (Effective 01/01/2024)
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral (Effective 01/01/2024)
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report (Effective 01/01/2024)
0859T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure) (Effective 01/01/2024)
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter) (Effective 01/01/2024)
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only (Effective 01/01/2024)
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only (Effective 01/01/2024)
Provisional Coverage	
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
0275T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia (Deleted 12/31/2023 – See 76999)

CPT Code	Description
Provisional Coverage	
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components) (Effective 07/01/2023)
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system) (Effective 07/01/2023)
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) (Effective 07/01/2023)
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components) (Effective 07/01/2023)
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component (Effective 07/01/2023)
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) (Effective 07/01/2023)
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker components) (Effective 07/01/2023)
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (Effective 07/01/2023)
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) (Effective 07/01/2023)
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers (Effective 07/01/2023)
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed (Effective 01/01/2024)
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed (Effective 01/01/2024)

CPT Code	Description
Provisional Coverage	
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed (Effective 01/01/2024)
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber (Effective 01/01/2024)

Questions and Answers

1	**Q:**	When a Category III CPT code is replaced by a Category I CPT code, is this item, service, or procedure presumed to be medically necessary?
	A:	No, additionally the absence of a CPT code from a CMS coverage policy does not indicate coverage.
2	**Q:**	What if a payment amount appears in the Medicare fee schedule for a service?
	A:	The presence of a payment amount in the Medicare Physician Fee Schedule (MPFS) and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service should be covered by Medicare.
3	**Q:**	Is prior authorization required?
	A:	Please check UnitedHealthcare Online for current status.

References

CMS National Coverage Determinations (NCDs)

NCD 20.8.4 Leadless Pacemakers
NCD 20.33 Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation
NCD 100.7 Colonic Irrigation
NCD 150.10 Lumbar Artificial Disc Replacement (LADR)
NCD 150.13 Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis
NCD 190.7 Human Tumor Stem Cell Drug Sensitivity Assays

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Category III Codes				
L35490 Category III Codes	A56902 Billing and Coding: Category III Codes	WPS*	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
Electroretinography (ERG)				
L38992 Electroretinography	A58706 Billing and Coding: Electroretinography (ERG)	CGS	KY, OH	KY, OH
L37398 Electroretinography (ERG)	A57677 Billing and Coding: Electroretinography (ERG)	First Coast	FL, PR, VI	FL, PR, VI
L36831 Visual Electrophysiology Testing	A57060 Billing and Coding: Visual Electrophysiology Testing	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L37371 Electroretinography (ERG)	A56672 Billing and Coding: Electroretinography (ERG)	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Electroretinography (ERG)				
L37015 Visual Electrophysiology Testing	A57599 Billing and Coding: Visual Electrophysiology Testing	WPS*	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
Extracorporeal Shock Wave Therapy (ESWT)				
L38775 Extracorporeal Shock Wave Therapy (ESWT)	A58367 Billing and Coding: Extracorporeal Shock Wave Therapy (ESWT)	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
Facet Joint Interventions				
L38773 Facet Joint Interventions for Pain Management	A58364 Billing and Coding: Facet Joint Interventions for Pain Management	CGS	KY, OH	KY, OH
L33930 Facet Joint Interventions for Pain Management	A57787 Billing and Coding: Facet Joint Interventions for Pain Management	First Coast	FL, PR, VI	FL, PR, VI
L35936 Facet Joint Interventions for Pain Management	A57826 Billing and Coding: Facet Joint Interventions for Pain Management	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L38801 Facet Joint Interventions for Pain Management	A58403 Billing and Coding: Facet Joint Interventions for Pain Management	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L38803 Facet Joint Interventions for Pain Management	A58405 Billing and Coding: Facet Joint Interventions for Pain Management	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34892 Facet Joint Interventions for Pain Management	A56670 Billing and Coding: Facet Joint Interventions for Pain Management	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38765 Facet Joint Interventions for Pain Management	A58350 Billing and Coding: Facet Joint Interventions for Pain Management	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L38841 Facet Joint Interventions for Pain Management	A58477 Billing and Coding: Facet Joint Interventions for Pain Management	WPS*	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
In Vitro Chemosensitivity & Chemoresistance Assays				
L37628 In Vitro Chemosensitivity & Chemoresistance Assays	A56071 Billing and Coding: In Vitro Chemosensitivity & Chemoresistance Assays	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L37630 In Vitro Chemosensitivity & Chemoresistance Assays	A56073 Billing and Coding: In Vitro Chemosensitivity & Chemoresistance Assays	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34554 In Vitro Chemosensitivity & Chemoresistance Assays	A56871 Billing and Coding: In Vitro Chemosensitivity & Chemoresistance Assays	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
Low-Level Laser Therapy				
L33631 Outpatient Physical and Occupational Therapy Services	A56566 Billing and Coding: Outpatient Physical and Occupational Therapy Services	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Lumbar Artificial Disc Replacement				
L37826 Lumbar Artificial Disc Replacement	A56390 Billing and Coding: Lumbar Artificial Disc Replacement	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Noncontact Near-Infrared Spectroscopy				
L39385 Near-Infrared Spectroscopy in Wound and Flap Management	A59158 Billing and Coding: Near-Infrared Spectroscopy in Wound and Flap Management	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
Platelet Rich Plasma				
L39023 Platelet Rich Plasma Injections for Non-Wound Injections	A58737 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections	CGS	KY, OH	KY, OH
L39071 Platelet Rich Plasma	A58810 Billing and Coding: Platelet Rich Plasma	First Coast	FL, PR, VI	FL, PR, VI
L38937 Platelet Rich Plasma	A58609 Billing and Coding: Platelet Rich Plasma	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L39058 Platelet Rich Plasma Injections for Non-Wound Injections	A58788 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L39060 Platelet Rich Plasma Injections for Non-Wound Injections	A58790 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L39068 Platelet Rich Plasma	A58808 Billing and Coding: Platelet Rich Plasma	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38745 Platelet Rich Plasma	A58282 Billing and Coding: Platelet Rich Plasma	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
Quantitative Sensory Testing (QST)				
L34859 Nerve Conduction Studies and Electromyography	A57123 Billing and Coding: Nerve Conduction Studies and Electromyography	First Coast	FL, PR, VI	FL, PR, VI
L35081 Nerve Conduction Studies and Electromyography	A54095 Billing and Coding: Nerve Conduction Studies and Electromyography	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers				

CMS Transmittal(s)

Transmittal 11457, Change Request 12761, Dated 06/15/2022 [July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)]
Transmittal 11472, Change Request 12773, Dated 06/23/2022 (July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System)
Transmittal 12053, Change Request 13210, Dated 05/18/2023 [July 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)]
Transmittal 12122, Charge Request 13216, Dated 07/05/2023 (July 2023 Update of the Ambulatory Surgical Center [ASC] Payment System)

MLN Matters

Article MM12761, July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
Article MM12773, July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
Article MM13210, July 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)
Article MM13216, July 2023 Update of the Ambulatory Surgical Center (ASC) Payment System

Related Medicare Advantage Coverage Summaries

Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements
Gastroesophageal and Gastrointestinal (GI) Services and Procedures
Glaucoma & Other Ophthalmic Surgical Treatments
Orthopedic Procedures, Devices, and Products
Radiation and Oncologic Procedures
Spine Procedures
Uterine Services and Procedures

Related Medicare Advantage Policy Guidelines

Anterior Segment Aqueous Drainage Device
Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)
Ocular Telescope

UnitedHealthcare Commercial Policies

Autologous Cellular Therapy
Abnormal Uterine Bleeding and Uterine Fibroids
Apheresis
Bariatric Surgery
Breast Imaging for Screening and Diagnosing Cancer
Category III Codes
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures
Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis
Discogenic Pain Treatment
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds
Gastrointestinal Motility Disorders, Diagnosis and Treatment
Lower Extremity Endovascular Procedures
Neurophysiologic Testing and Monitoring
Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds
Omnibus Codes
Prolotherapy and Platelet Rich Plasma Therapies
Prostate Surgeries and Interventions
Spinal Fusion and Bone Healing Enhancement Products
Spinal Fusion and Decompression
Surgery of the Knee
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins
Transcatheter Heart Valve Procedures
Transcranial Magnetic Stimulation
Vertebral Body Tethering for Scoliosis
Visual Information Processing Evaluation and Orthoptic and Vision Therapy

Other

Medicare Managed Care Manual IOM Pub. No. 100-16, Ch. 4, §90.5
Physician Fee Schedule Relative Value Files
Social Security Act (Title XVIII), Section 1862(a)(1)(A) Medically Reasonable & Necessary

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
06/01/2024	**References** ***Related Medicare Advantage Coverage Summaries*** • Updated reference link to reflect the current policy title for *Glaucoma & Other Ophthalmic Surgical Treatments*
05/01/2024	**Policy Summary** ***Guidelines*** • Removed content/language addressing: ○ Computed tomography cerebral perfusion analysis (CTP) (CPT code 0042T) ○ Transcatheter placement of extracranial vertebral artery stent(s) (CPT codes 0075T and 0076T) ○ Cervical artificial disc replacement (CPT code 0098T) ○ Transanal endoscopic microsurgery (CPT code 0184T) ○ Intraocular pressure measurement (CPT codes 0198T and 0329T) ○ Percutaneous sacral augmentation (sacroplasty) (CPT codes 0200T and 0201T) ○ Anterior segment aqueous drainage device (CPT codes 0253T, 0449T, 0450T, 0474T, and 0671T) ○ Ocular telescope (CPT code 0308T) ○ High dose rate electronic brachytherapy (CPT codes 0394T and 0395T) ○ Magnetic resonance image guided high intensity focused ultrasound (MRGFUS) (CPT code 0398T) ○ Destruction of neurofibroma (CPT codes 0419T and 0420T) ○ Transurethral waterjet ablation of prostate (CPT code 0421T) ○ Neurostimulator system for treatment of central sleep apnea (CPT codes 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T) ○ Myocardial contrast perfusion echocardiography (CPT code 0439T) ○ Implantable interstitial glucose sensor (CPT codes 0446T, 0447T, and 0448T) ○ Suprachoroidal injection of a pharmacologic agent (CPT code 0465T) ○ White blood cell concentrate injection (CPT code 0481T) ○ Surgical preparation of cadaver donor lung(s) (CPT codes 0494T and 0495T) ○ Electroretinography (ERG) (CPT code 0509T) ○ Balloon sclerotherapy (CPT code 0524T) ○ Movement disorder analysis (CPT codes 0533T, 0534T, 0535T, and 0536T) ○ Chimeric antigen receptor t-cell (car-t) therapy (CPT codes 0537T, 0538T, 0539T, and 0540T) ○ Magnetocardiography (MCG) (CPT codes 0541T and 0542T) ○ Radiofrequency spectroscopy (CPT code 0546T) ○ Bone-material quality testing by microindentation(s) (CPT code 0547T) ○ Low level/cold laser light therapy (LLLT) (CPT code 0552T) ○ Iliac arteriovenous anastomosis implant (CPT code 0553T) ○ Bone mass measurement (CPT codes 0554T, 0555T, 0556T, 0557T, and 0558T) ○ Female voiding prosthesis (CPT codes 0596T and 0597T) ○ Transdermal glomerular filtration rate (GFR) measurement(s) (CPT codes 0602T and 0603T) ○ Optical coherence tomography (OCT) of retina (CPT codes 0604T, 0605T, and 0606T) ○ Magnetic resonance spectroscopy (CPT codes 0609T, 0610T, 0611T, and 0612T) ○ Interatrial septal shunt device implantation (CPT code 0613T) ○ Cystourethroscopy with transurethral anterior prostate commissurotomy (CPT code 0619T) ○ Endovascular venous arterialization (CPT code 0620T) ○ Trabeculostomy procedure by laser (ab interno) (CPT codes 0621T and 0622T) ○ Automated analysis of coronary atherosclerotic plaque (CPT codes 0623T, 0624T, 0625T, and 0626T) ○ Transcatheter ultrasound nerve ablation (CPT code 0632T) ○ Cerebrospinal fluid shunt analysis (CPT code 0639T)

Date	Summary of Changes
	○ Transcatheter implantation and removal procedures (CPT codes 0643T, 0644T, and 0645T) ○ Quantitative magnetic resonance tissue composition analysis (CPT codes 0648T and 0649T) ○ Esophagogastroduodenoscopy (CPT codes 0652T, 0653T, and 0654T) ○ Drug-eluting implant procedures in eye (CPT codes 0660T and 0661T) ○ Scalp cooling (CPT codes 0662T and 0663T) ○ Benign thyroid nodule ablation (CPT code 0673T) ○ Diaphragmatic stimulation system (CPT codes 0674T, 0675T, 0677T, 0679T, 0680T, 0681T, 0682T, 0683T, 0684T, and 0685T) ○ Malignant hepatocellular histotripsy (CPT code 0686T) ○ Quantitative ultrasound tissue characterization (CPT code 0689T) ○ Automated analysis of vertebral fracture (CPT code 0691T) ○ Posterior chamber injection (CPT code 0699T) ○ Molecular fluorescent imaging of suspicious nevus (CPT code 0700T) ○ Subchondral bone defect injection (CPT code 0707T) ○ Intradermal immunotherapy (CPT code 0708T) ○ Noninvasive arterial plaque analysis (CPT codes 0710T, 0711T, 0712T, and 0713T) ○ Coronary artery disease (CAD) risk score analysis (CPT code 0716T) ○ Tissue characterization by quantitative computed tomography (CPT code 0721T) ○ Quantitative magnetic resonance cholangiopancreatography (GMRCP) (CPT code 0723T) ○ Vestibular device procedures (CPT codes 0725T, 0726T, 0727T, 0728T, and 0729T) ○ Ai-based facial phenotype analysis (CPT code 0731T) ○ Immunotherapy administration with electroporation (CPT code 0732T) ○ Remote body and limb kinematic measurement-based therapy (CPT codes 0733T and 0734T) ○ Remote insulin dose calculation and monitoring system (CPT codes 0740T and 0741T) ○ Absolute quantitation of myocardial blood flow (AQMBF) (CPT code 0742T) ○ Cardiac radioablation (CPT codes 0745T, 0746T, and 0747T) ○ Stem cell injection for perianal fistula (CPT code 0748T) ○ Risk-based assessment for cardiac dysfunction (CPT code 0765T) ○ Virtual reality technology services (CPT codes 0771T and 0773T) ○ Intra-brain hypothermia induction (CPT code 0776T) ○ Bronchoscopy with radiofrequency destruction of the pulmonary nerves (CPT codes 0781T and 0782T) ○ Virtual reality–facilitated gait training (CPT code 0791T) ○ Transcatheter thermal nerve ablation with catheterization and angiography (CPT code 0793T) ○ Pharmaco-oncologic treatment planning (CPT code 0794T) ○ Pulmonary tissue ventilation analysis (CPT codes 0807T and 0808T) ○ Subretinal injection with vitrectomy and retinotomies (CPT code 0810T) **Lumbar Artificial Disc Replacement (CPT Code 0165T)** • Updated list of applicable CPT codes; removed 0164T **Transluminal Peripheral Atherectomy (CPT Codes 0234T, 0235T, 0236T, and 0237T)** • Updated list of applicable CPT codes; removed 0238T • Updated language pertaining to states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs): ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* **Automated Visual Evoked Potentials (VEPs) for Visual Acuity Screening (CPT Code 0333T)** • Modified content heading • Updated language pertaining to states/territories with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*

Date	Summary of Changes

	Radiostereometric Analysis (RSA) (CPT Codes 0347T, 0348T, 0349T, and 0350T)
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Lower Extremity Endovascular Procedures (CPT Codes 0238T and 0505T)
	• Modified content heading
	• Updated list of applicable CPT codes; added 0238T
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Lower Extremity Endovascular Procedures* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Wireless Cardiac Stimulator for Left Ventricular Pacing (CPT Codes 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0861T, 0862T, and 0863T)
	• Updated list of applicable CPT codes; added 0861T, 0862T, and 0863T
	Sonosalpingography (CPT Code 0568T)
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Implantable Cardioverter-Defibrillator System with Substernal Electrode (CPT Codes 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, and 0580T)
	• Updated list of applicable CPT codes; removed 0614T
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Limb Lengthening Procedure (CPT Code 0594T)
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Irreversible Electroporation (IRE) Ablation (CPT Codes 0600T and 0601T)
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Remote Monitoring of an External Continuous Pulmonary Fluid Monitoring System (CPT Codes 0607T and 0608T)
	• Modified content heading
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines
	  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes*
	Eye-Movement Analysis without Spatial Calibration (CPT Code 0615T)
	• Updated language pertaining to states/territories with no LCDs/LCAs:
	  ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines

Date	Summary of Changes
	○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* Iris Prosthesis Insertion (CPT Codes 0616T, 0617T, and 0618T) • Updated language pertaining to states/territories with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* Non-Contact Near-Infrared Spectroscopy (NIRS) (CPT Codes 0640T and 0859T) • Updated list of applicable CPT codes: ○ Added 0859T ○ Removed 0641T and 0642T Intracoronary Infusion of Supersaturated Oxygen (CPT Code 0659T) • Updated language pertaining to states/territories with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* Electrocardiographic Body Surface Mapping (CPT Codes 0695T and 0696T) • Modified content heading • Updated language pertaining to states/territories with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* Bone Strength and Fracture-Risk Assessment Using Digital X-Ray Radiogrammetry-Bone Mineral Density (DXR-BMD) (CPT Codes 0749T and 0750T) • Modified content heading • Updated list of applicable CPT codes; removed 0743T Silver Diamine Fluoride for Dental Caries (CPT Code 0792T) • Revised language to indicate this service has a status indicator of 'N' (Non-Covered) on the National Physician Fee Schedule; this service is not covered by Medicare Leadless Pacemakers (CPT Codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 0823T, 0824T, 0825T, and 0826T) • Modified content heading • Updated list of applicable CPT codes; added 0823T, 0824T, 0825T, and 0826T Caval Valve Implantation (CAVI) (CPT Codes 0805T and 0806T) • Updated language pertaining to states/territories with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Transcatheter Heart Valve Procedures* for coverage guidelines ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Category III Codes* Esophagogastroduodenoscopy with Intragastric Bariatric Balloon Adjustment (CPT Code 0813T) *(new to policy)* • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) and LCDs/LCAs do not exist ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Bariatric Surgery* Injectable Bone Substitutes (CPT Code 0814T) *(new to policy)* • Added language to indicate: ○ Medicare does not have a NCD and LCDs/LCAs do not exist ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Bone Healing Enhancement Products*

Date	Summary of Changes

	Transcranial Magnetic Stimulation with Concomitant Measurement of Evoked Cortical Potentials (CPT Code 0858T) *(new to policy)*
	• Added language to indicate:
	  ○ Medicare does not have a NCD and LCDs/LCAs do not exist
	  ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Transcranial Magnetic Stimulation*
	Applicable Codes
	CPT Codes
	Non-Covered
	• Added notation to indicate:
	  ○ 0198T and 0329T were "deleted Feb. 29, 2024"
	  ○ 0743T was "deleted Dec. 31, 2023"
	  ○ 0552T was "deleted Sep. 30, 2023"
	• Added 0813T, 0814T, 0858T, 0859T, 0861T, 0862T, and 0863T
	• Removed 0200T, 0201T, 0312T, 0313T, 0314T, 0315T, 0316T, 0317T, 0419T, 0420T, 0474T, 0481T, 0487T, 0488T, 0491T, 0492T, 0493T, 0494T, 0495T, 0524T, 0541T, 0542T, 0546T, 0547T, 0553T, 0591T, 0592T, 0593T, 0596T, 0597T, 0602T, 0603T, 0604T, 0605T, 0606T, 0609T, 0610T, 0611T, 0612T, 0613T, 0614T, 0619T, 0620T, 0621T, 0622T, 0623T, 0624T, 0625T, 0626T, 0632T, 0639T, 0643T, 0644T, 0645T, 0648T, 0649T, 0660T, 0661T, 0673T, 0674T, 0675T, 0677T, 0679T, 0680T, 0681T, 0682T, 0683T, 0684T, 0685T, 0689T, 0691T, 0699T, 0700T, 0707T, 0708T, 0710T, 0711T, 0712T, 0713T, 0716T, 0721T, 0723T, 0725T, 0726T, 0727T, 0728T, 0729T, 0731T, 0732T, 0733T, 0734T, 0740T, 0741T, 0745T, 0746T, 0747T, 0748T, 0765T, 0771T, 0773T, 0776T, 0781T, 0782T, 0791T, 0793T, 0794T, 0807T, 0808T, and 0810T
	Provisional Coverage
	• Added 0823T, 0824T, 0825T, and 0826T
	• Removed 0042T, 0075T, 0076T, 0098T, 0164T, 0184T, 0253T, 0308T, 0394T, 0395T, 0398T, 0421T, 0439T, 0446T, 0447T, 0448T, 0449T, 0450T, 0501T, 0502T, 0503T, 0504T, 0509T, 0537T, 0538T, 0539T, 0540T, 0554T, 0555T, 0556T, 0557T, 0558T, 0652T, 0653T, 0654T, 0662T, 0663T, 0671T, and 0742T
	References
	CMS National Coverage Determinations (NCDs) and ***UnitedHealthcare Commercial Policies***
	• Updated list of applicable reference links to reflect the most current information
	CMS Local Coverage Determinations (LCDs) and Articles
	• Updated list of applicable reference links to reflect the most current information
	• Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
	Administrative
	• Archived previous policy version MPG043.38

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this policy guideline have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this policy guideline. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.