

# Category III CPT Codes

**Guideline Number:** MPG043.37  
**Approval Date:** December 13, 2023

[↪ Terms and Conditions](#)

Table of Contents	Page
<a href="#">Policy Summary</a> .....	1
<a href="#">Applicable Codes</a> .....	19
<a href="#">Questions and Answers</a> .....	40
<a href="#">References</a> .....	40
<a href="#">Guideline History/Revision Information</a> .....	50
<a href="#">Purpose</a> .....	64
<a href="#">Terms and Conditions</a> .....	65

Related Policies
See <a href="#">References</a>

## 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 technical 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.

### ***Computed Tomography Cerebral Perfusion Analysis (CTP) (CPT Code 0042T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Computed Tomography Cerebral Perfusion Analysis \(CTP\)](#).

### ***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](#).

### ***Transcatheter Placement of Extracranial Vertebral Artery Stent(s) (CPT Codes 0075T and 0076T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Category III Codes](#).

### ***Cervical Artificial Disc Replacement (CPT Code 0098T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Cervical Artificial Disc Replacement](#).

### ***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 Codes 0164T and 0165T)***

Lumbar artificial disc replacement (LADR) for the 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](#).

### ***Transanal Endoscopic Microsurgery (CPT Code 0184T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Transanal Endoscopic Surgery \(TES\)](#).

### ***Intraocular Pressure Measurement (CPT Codes 0198T and 0329T)***

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 [Corneal Hysterisis and Intraocular Pressure Measurement](#).

### ***Percutaneous Sacral Augmentation (Sacroplasty) (CPT Codes 0200T and 0201T)***

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 [Minimally Invasive Spine Surgery Procedures](#).

### ***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, 0237T, and 0238T)***

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 [Category III Codes](#).

### ***Anterior Segment Aqueous Drainage Device (CPT Codes 0253T, 0449T, 0450T, 0474T, and 0671T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Micro-Invasive Glaucoma Surgery \(MIGS\)](#). Refer also the Medicare Advantage Policy Guideline titled [Anterior Segment Aqueous Drainage Device](#).

### ***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](#).

### ***Ocular Telescope (CPT Code 0308T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Implantable Miniature Telescope \(IMT\)](#). Refer also the Medicare Advantage Policy Guideline titled [Ocular Telescope](#).

### ***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](#).

### ***Visual Evoked Potential, Screening of Visual Acuity (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 Policies titled [Category III 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 [Category III 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](#).

### ***High Dose Rate Electronic Brachytherapy (CPT Codes 0394T and 0395T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Category III 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](#).

### ***Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)***

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 [Category III Codes](#) and [Magnetic-Resonance-Guided Focused Ultrasound Surgery \(MRgFUS\)](#).

***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](#).

***Destruction of Neurofibroma (CPT Codes 0419T and 0420T)***

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 [Category III Codes](#).

***Transurethral Waterjet Ablation of Prostate (CPT Code 0421T)***

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 [Fluid Jet System](#).

***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](#).

***Neurostimulator System for Treatment of Central Sleep Apnea (CPT Codes 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T)***

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 [Obstructive and Central Sleep Apnea Treatment](#).

***Myocardial Contrast Perfusion Echocardiography (CPT Code 0439T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Myocardial Contrast Perfusion Echocardiography](#).

***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](#).

***Implantable Interstitial Glucose Sensor (CPT Codes 0446T, 0447T, and 0448T)***

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 [Implantable Continuous Glucose Monitors](#).

***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 Policies titled [Neurophysiologic Testing and Monitoring](#).

### ***Suprachoroidal Injection of a Pharmacologic Agent (CPT Code 0465T)***

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 [Category III Codes](#).

### ***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](#).

### ***White Blood Cell Concentrate Injection (CPT Code 0481T)***

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 [Category III 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](#).

### ***Surgical Preparation of Cadaver Donor Lung(s) (CPT Codes 0494T and 0495T)***

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 [Category III Codes](#).

### ***Endovenous Femoral-Popliteal Arterial Revascularization (CPT Code 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 [Category III Codes](#).

### ***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](#).

### ***Electroretinography (ERG) (CPT Code 0509T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Electroretinography \(ERG\)](#).

### ***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, and 0522T)***

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](#).

### ***Balloon Sclerotherapy (CPT Code 0524T)***

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 [Category III 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 Policies titled [Omnibus Codes](#).

### ***Movement Disorder Analysis (CPT Codes 0533T, 0534T, 0535T, and 0536T)***

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](#).

### ***Chimeric Antigen Receptor T-cell (CAR-T) Therapy (CPT Codes 0537T, 0538T, 0539T and 0540T)***

CMS covers autologous treatment for cancer with T-cells expressing at least one chimeric antigen receptor (CAR) when administered at healthcare facilities enrolled in the FDA risk evaluation and mitigation strategies (REMS) and used for a medically accepted indication as defined at Social Security Act section 1861(t)(2). Refer to the NCD [Chimeric Antigen Receptor \(CAR\) T-cell Therapy \(110.24\)](#).

### ***Magnetocardiography (MCG) (CPT Codes 0541T and 0542T)***

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 [Category III 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](#).

### ***Radiofrequency Spectroscopy (CPT Code 0546T)***

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 [Category III Codes](#).

### ***Bone-Material Quality Testing by Microindentation(s) (CPT Code 0547T)***

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 [Category III Codes](#).

### ***Low Level/Cold Laser Light Therapy (LLLT) (CPT Code 0552T)***

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 [Low-Level Laser Therapy](#). For coverage guidelines, for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policies titled [Category III Codes](#).

### ***Iliac Arteriovenous Anastomosis Implant (CPT Code 0553T)***

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 [Category III Codes](#).

### ***Bone Mass Measurement (CPT Codes 0554T, 0555T, 0556T, 0557T, and 0558T)***

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 [Bone Mineral Density Studies](#).

### ***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 [Category III Codes](#).

### ***Implantable Cardioverter-Defibrillator System with Substernal Electrode (CPT Codes 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, and 0614T)***

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 [Category III 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 Thermoablation (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 [Category III Codes](#).

### ***Female Voiding Prosthesis (CPT Codes 0596T and 0597T)***

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 [Category III 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 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 [Category III Codes](#).

### ***Transdermal Glomerular Filtration Rate (GFR) Measurement(s) (CPT Codes 0602T and 0603T)***

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 [Category III Codes](#).

### ***Optical Coherence Tomography (OCT) of Retina (CPT Codes 0604T, 0605T, and 0606T)***

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 [Category III Codes](#).

### ***Remote Monitoring of Pulmonary 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 [Category III Codes](#).

### ***Magnetic Resonance Spectroscopy (CPT Codes 0609T, 0610T, 0611T, and 0612T)***

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 [Category III Codes](#).

### ***Interatrial Septal Shunt Device Implantation (CPT Code 0613T)***

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 [Category III 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 [Category III 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 [Category III Codes](#).

### ***Cystourethroscopy with Transurethral Anterior Prostate Commissurotomy (CPT Code 0619T)***

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 [Category III Codes](#).

### ***Endovascular Venous Arterialization (CPT Code 0620T)***

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 [Category III Codes](#).

### ***Trabeculostomy Procedure by Laser (Ab Interno) (CPT Codes 0621T and 0622T)***

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 [Category III Codes](#).

### ***Automated Analysis of Coronary Atherosclerotic Plaque (CPT Codes 0623T, 0624T, 0625T, and 0626T)***

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 [Category III 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](#).

### ***Transcatheter Ultrasound Nerve Ablation (CPT Code 0632T)***

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 [Category III 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](#).

### ***Cerebrospinal Fluid Shunt Analysis (CPT Code 0639T)***

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 [Category III Codes](#).

### ***Non-contact Near-Infrared Spectroscopy (NIRS) (CPT Code 0640T, 0641T, and 0642T)***

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](#).

### ***Transcatheter Implantation and Removal Procedures (CPT Code 0643T, 0644T, and 0645T)***

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 [Category III 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](#).

### ***Quantitative Magnetic Resonance Tissue Composition Analysis (CPT Codes 0648T and 0649T)***

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 [Category III 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](#).

### ***Esophagogastroduodenoscopy (CPT Code 0652T, 0653T, and 0654T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Esophagogastroduodenoscopy](#).

### ***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 [Category III Codes](#).

### ***Drug-Eluting Implant Procedures in Eye (CPT Codes 0660T and 0661T)***

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 [Category III Codes](#).

### ***Scalp Cooling (CPT Codes 0662T and 0663T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Scalp Cooling](#).

### ***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](#).

### ***Benign Thyroid Nodule Ablation (CPT Code 0673T)***

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 [Category III Codes](#).

***Diaphragmatic Stimulation System (CPT Codes 0674T, 0675T, 0677T, 0679T, 0680T, 0681T, 0682T, 0683T, 0684T, and 0685T)***

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 [Category III Codes](#).

***Malignant Hepatocellular Histotripsy (CPT Code 0686T)***

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 [Category III 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](#).

***Quantitative Ultrasound Tissue Characterization (CPT Code 0689T)***

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 [Category III Codes](#).

***Automated Analysis of Vertebral Fracture (CPT Code 0691T)***

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 [Category III Codes](#).

***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](#).

***Mapping of Pacemaker or Pacing Cardioverter-Defibrillator Lead(s) (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 [Category III Codes](#).

### ***Posterior Chamber Injection (CPT Code 0699T)***

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 [Category III Codes](#).

### ***Molecular Fluorescent Imaging of Suspicious Nevus (CPT Code 0700T)***

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 [Category III Codes](#).

### ***Subchondral Bone Defect Injection (CPT Code 0707T)***

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 [Category III Codes](#).

### ***Intradermal Immunotherapy (CPT Code 0708T)***

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 [Category III Codes](#).

### ***Noninvasive Arterial Plaque Analysis (CPT Codes 0710T, 0711T, 0712T, and 0713T)***

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 [Category III 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](#).

### ***Coronary Artery Disease (CAD) Risk Score Analysis (CPT Code 0716T)***

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 [Category III Codes](#).

### ***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](#).

### ***Tissue Characterization by Quantitative Computed Tomography (CPT Code 0721T)***

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 [Category III Codes](#).

### ***Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) (CPT Code 0723T)***

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 [Category III Codes](#).

### ***Vestibular Device Procedures (CPT Codes 0725T, 0726T, 0727T, 0728T, and 0729T)***

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 [Category III Codes](#).

### ***AI-Based Facial Phenotype Analysis (CPT Code 0731T)***

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 [Category III Codes](#).

### ***Immunotherapy Administration With Electroporation (CPT Code 0732T)***

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 [Category III Codes](#).

### ***Remote Body And Limb Kinematic Measurement-Based Therapy (CPT Codes 0733T and 0734T)***

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 [Category III Codes](#).

### ***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](#).

### ***Remote Insulin Dose Calculation and Monitoring System (CPT Codes 0740T and 0741T)***

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 [Category III Codes](#).

### ***Absolute Quantitation of Myocardial Blood Flow (AQMBF) (CPT Code 0742T)***

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. Refer to the references table for [Absolute Quantitation of Myocardial Blood Flow \(AQMBF\)](#).



### ***Bone Strength and Fracture-Risk Assessment (CPT Codes 0743T, 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](#).

### ***Cardiac Radioablation (CPT Codes 0745T, 0746T, and 0747T)***

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 [Category III Codes](#).

### ***Stem Cell Injection for Perianal Fistula (CPT Code 0748T)***

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 [Category III Codes](#).

### ***Risk-Based Assessment for Cardiac Dysfunction (CPT Code 0765T)***

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 [Category III Codes](#).

### ***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](#).

### ***Virtual Reality Technology Services (CPT Codes 0771T and 0773T)***

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 [Category III 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](#).

### ***Intra-Brain Hypothermia Induction (CPT Code 0776T)***

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 [Category III Codes](#).

### ***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](#).

### ***Bronchoscopy with Radiofrequency Destruction of the Pulmonary Nerves (CPT Codes 0781T and 0782T)***

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 [Category III Codes](#).

### ***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](#).

### ***Virtual Reality–Facilitated Gait Training (CPT Code 0791T)***

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 [Category III Codes](#).

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

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 [Category III Codes](#).

### ***Transcatheter Thermal Nerve Ablation with Catheterization and Angiography (CPT Code 0793T)***

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 [Category III Codes](#).

### ***Pharmaco-Oncologic Treatment Planning (CPT Code 0794T)***

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 [Category III Codes](#).

### ***Permanent Dual-Chamber Leadless Pacemaker (CPT Codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, and 0804T)***

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 [Category III Codes](#).

### ***Pulmonary Tissue Ventilation Analysis (CPT Codes 0807T and 0808T)***

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 [Category III Codes](#).

## Subretinal Injection with Vitrectomy and Retinotomies (CPT Code 0810T)

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 [Category III Codes](#).

## 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
<b>Non-Covered</b>	
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

CPT Code	Description
<b>Non-Covered</b>	
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed
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)
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

CPT Code	Description
<b>Non-Covered</b>	
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	Bone m
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)
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)
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming (Deleted 12/31/2022 – See 64999)
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator (Deleted 12/31/2022 –See 64999)

CPT Code	Description
<b>Non-Covered</b>	
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator (Deleted 12/31/2022 – See 64999)
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator (Deleted 12/31/2022 – See 64999)
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator (Deleted 12/31/2022 – See 64999)
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed (Deleted 12/31/2022 – See 64999)
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
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)
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

CPT Code	Description
<b>Non-Covered</b>	
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
0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas
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)

CPT Code	Description
<b>Non-Covered</b>	
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea (Deleted 12/31/2023)
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
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Anterior Segment Aqueous Drainage Device</a> )
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)
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed
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
0487T	Biomechanical mapping, transvaginal, with report (Deleted 12/31/2022 – See 58999)
0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days (Deleted 12/31/2022)



CPT Code	Description
<b>Non-Covered</b>	
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
0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq cm or less (Deleted 12/31/2022 – See 17999)
0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Deleted 12/31/2022 – See 17999)
0493T	Near-infrared spectroscopy studies of lower extremity wounds (e.g., for oxyhemoglobin measurement) (Deleted 12/31/2022 – See 93998)
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field
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
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

CPT Code	Description
<b>Non-Covered</b>	
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
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring
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
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)
0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;

CPT Code	Description
<b>Non-Covered</b>	
0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report
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
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report
0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
0553T	Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention
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
<b>Non-Covered</b>	
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)
0591T	Health and well-being coaching face-to-face; individual, initial assessment (Deleted 12/31/2022)
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes (Deleted 12/31/2022)
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes (Deleted 12/31/2022)
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
0596T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); initial insertion, including urethral measurement
0597T	Temporary female intraurethral valve-pump (i.e., voiding prosthesis); replacement
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)

CPT Code	Description
<b>Non-Covered</b>	
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
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours
0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision, set-up and patient education on use of equipment
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days
0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days
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
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
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (i.e., lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report
0613T	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed
0614T	Removal and replacement of substernal implantable defibrillator pulse generator
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

CPT Code	Description
<b>Non-Covered</b>	
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed
0620T	Endovascular venous arterialization, tibial or peroneal vein, 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
0621T	Trabeculostomy ab interno by laser
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report
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
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
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)

CPT Code	Description
<b>Non-Covered</b>	
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed
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 [StO <sub>2</sub> ]); 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 [StO <sub>2</sub> ]); interpretation and report only, each flap or wound (Deleted 12/31/2023 – See 0640T, 0859T)
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach
0644T	Transcatheter removal or debulking of intracardiac mass (e.g., vegetations, thrombus) via suction (e.g., vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed
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
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session; single organ
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure)
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
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor

CPT Code	Description
<b>Non-Covered</b>	
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 (Effective 01/01/2022)
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance
0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)
0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead
0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads
0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0683T	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, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0685T	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session (Effective 01/01/2022)



CPT Code	Description
<b>Non-Covered</b>	
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 (Effective 01/01/2022)
0689T	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (e.g., organ, gland, tissue, target structure) (Effective 01/01/2022)
0691T	Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report (Effective 01/01/2022)
0692T	Therapeutic ultrafiltration (Effective 01/01/2022)
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report (Effective 01/01/2022)
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 (Effective 01/01/2022)
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 (Effective 01/01/2022)
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 (Effective 01/01/2022)
0699T	Injection, posterior chamber of eye, medication (Effective 01/01/2022)
0700T	Molecular fluorescent imaging of suspicious nevus; first lesion (Effective 01/01/2022)
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment (Effective 01/01/2022)
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 (Effective 01/01/2022)
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month (Effective 01/01/2022)
0707T	Injection(s), bone substitute material (e.g., calcium phosphate) into subchondral bone defect (i.e., bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization (Effective 01/01/2022)
0708T	Intradermal cancer immunotherapy; preparation and initial injection (Effective 01/01/2022)
0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report (Effective 01/01/2022)
0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission (Effective 01/01/2022)
0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability (Effective 01/01/2022)
0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report (Effective 01/01/2022)

CPT Code	Description
<b>Non-Covered</b>	
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance (Effective 07/01/2022)
0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score (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)
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging (Effective 07/01/2022)
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session (Effective 07/01/2022)
0725T	Vestibular device implantation, unilateral (Effective 07/01/2022)
0726T	Removal of implanted vestibular device, unilateral (Effective 07/01/2022)
0727T	Removal and replacement of implanted vestibular device, unilateral (Effective 07/01/2022)
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming (Effective 07/01/2022)
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming (Effective 07/01/2022)
0731T	Augmentative AI-based facial phenotype analysis with report (Effective 07/01/2022)
0732T	Immunotherapy administration with electroporation, intramuscular (Effective 07/01/2022)
0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days (Effective 07/01/2022)
0734T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month (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)
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education (Effective 01/01/2023)
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days (Effective 01/01/2023)

CPT Code	Description
<b>Non-Covered</b>	
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)
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)
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (e.g., CT, MRI, or myocardial perfusion scan) and electrical data (e.g., 12-lead ECG data), and identification of areas of avoidance (Effective 01/01/2023)
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan (Effective 01/01/2023)
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia (Effective 01/01/2023)
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (e.g., removal of setons, fistula curettage, closure of internal openings) (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)
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (e.g., low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram (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)
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)

CPT Code	Description
<b>Non-Covered</b>	
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older (Effective 01/01/2023)
0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older (Effective 01/01/2023)
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)
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (e.g., vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment (Effective 01/01/2023)
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)
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi (Effective 01/01/2023)
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus (Effective 01/01/2023)
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment (Effective 01/01/2023)
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure) (Effective 07/01/2023)
0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional (Effective 07/01/2023)
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance (Effective 07/01/2023)
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately (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)
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report (Effective 07/01/2023)

CPT Code	Description
<b>Non-Covered</b>	
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report (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)
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies (Effective 07/01/2023)
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)
<b>Provisional Coverage</b>	
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
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)
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full thickness)
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Anterior Segment Aqueous Drainage Device</a> )
0275T	Percutaneous laminotomy/laminectomy (intradiscal 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
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Ocular Telescope</a> )
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)

CPT Code	Description
<b>Provisional Coverage</b>	
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Anterior Segment Aqueous Drainage Device</a> )
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure) (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Anterior Segment Aqueous Drainage Device</a> )
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report [Refer to the Medicare Advantage Policy Guideline titled <a href="#">Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)</a> ] (Deleted 12/31/2023 – See 75580)
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission [Refer to the Medicare Advantage Policy Guideline titled <a href="#">Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)</a> ] (Deleted 12/31/2023 – See 75580)
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model [Refer to the Medicare Advantage Policy Guideline titled <a href="#">Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)</a> ] (Deleted 12/31/2023 – See 75580)
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report [Refer to the Medicare Advantage Policy Guideline titled <a href="#">Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)</a> ] (Deleted 12/31/2023 – See 75580)
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia (Deleted 12/31/2023 – See 76999)
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day (Bundled)
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage) (Bundled)
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration (Bundled)
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous

CPT Code	Description
<b>Provisional Coverage</b>	
0554T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report
0555T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data
0556T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density
0557T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple
0654T	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device (List separately in addition to code for primary procedure)
0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more (Effective 01/01/2022) (Refer to the Medicare Advantage Policy Guideline titled <a href="#">Anterior Segment Aqueous Drainage Device</a> )
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure) (Effective 01/01/2023)
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)

CPT Code	Description
<b>Provisional Coverage</b>	
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)

*CPT® is a registered trademark of the American Medical Association*

## Questions and Answers

1	<b>Q:</b>	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?
	<b>A:</b>	No, additionally the absence of a CPT code from a CMS coverage policy does not indicate coverage.
2	<b>Q:</b>	What if a payment amount appears in the Medicare fee schedule for a service?
	<b>A:</b>	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	<b>Q:</b>	Is prior authorization required?
	<b>A:</b>	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 110.24 Chimeric Antigen Receptor \(CAR\) T-cell Therapy](#)

[NCD 150.10 Lumbar Artificial Disc Replacement \(LADR\)](#)

[NCD 150.13 Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis](#)

[NCD 150.3 Bone \(Mineral\) Density Studies](#)

[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
<b>Category III Codes</b>				
<a href="#">L35490 Category III Codes</a>	<a href="#">A56902 Billing and Coding: Category III Codes</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	KS, IA, MO, NE, MI, IN
<b>Absolute Quantitation of Myocardial Blood Flow (AQMBF)</b>				
<a href="#">L38396 Cardiology Non-emergent Outpatient Stress Testing</a>	<a href="#">A56952 Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L35083 Cardiology Non-emergent Outpatient Stress Testing</a>	<a href="#">A56423 Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing</a>	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
<b>Bone Mineral Density Studies</b>				
<a href="#">L36460 Bone Mass Measurement</a>	<a href="#">A57132 Billing and Coding: Bone Mass Measurement</a>	CGS	KY, OH	KY, OH
<a href="#">L39268 Bone Mass Measurement</a>	<a href="#">A59040 Billing and Coding: Bone Mass Measurement</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Cardiac Computed Tomography &amp; Angiography</b>				
<a href="#">L38771 Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	<a href="#">A58359 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	CGS	KY, OH	KY, OH
<a href="#">L39075 Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	<a href="#">A58814 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38613 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	<a href="#">A58095 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38615 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	<a href="#">A58097 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38278 Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	<a href="#">A58406 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>Cardiac Computed Tomography &amp; Angiography</b>				
<a href="#">L38839 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	<a href="#">A58473 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	KS, IA, MO, NE, MI, IN
<b>Cervical Artificial Disc Replacement</b>				
<a href="#">L38033 Cervical Disc Replacement</a>	<a href="#">A57021 Billing and Coding: Cervical Disc Replacement</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Computed Tomography Cerebral Perfusion Analysis (CTP)</b>				
N/A	<a href="#">A58218 Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	CGS	KY, OH	KY, OH
<a href="#">L38667 Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	<a href="#">A58152 Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38709 Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	<a href="#">A58223 Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38700 Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	<a href="#">A58225 Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38769 Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	<a href="#">A58354 Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Electroretinography (ERG)</b>				
<a href="#">L38992 Electroretinography (ERG)</a>	<a href="#">A58706 Billing and Coding: Electroretinography (ERG)</a>	CGS	KY, OH	KY, OH
<a href="#">L37398 Electroretinography (ERG)</a>	<a href="#">A57677 Billing and Coding: Electroretinography (ERG)</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L36831 Visual Electrophysiology Testing</a>	<a href="#">A57060 Billing and Coding: Visual Electrophysiology Testing</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L37371 Electroretinography (ERG)</a>	<a href="#">A56672 Billing and Coding: Electroretinography (ERG)</a>	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
<b>Electroretinography (ERG)</b>				
<a href="#">L37015 Visual Electrophysiology Testing</a>	<a href="#">A57599 Billing and Coding: Visual Electrophysiology Testing</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
<b>Esophagogastroduodenoscopy</b>				
<a href="#">L34434 Upper Gastrointestinal Endoscopy and Visualization</a>	<a href="#">A56389 Billing and Coding: Upper Gastrointestinal Endoscopy and Visualization</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Extracorporeal Shock Wave Therapy (ESWT)</b>				
<a href="#">L38775 Extracorporeal Shock Wave Therapy (ESWT)</a>	<a href="#">A58367 Billing and Coding: Extracorporeal Shock Wave Therapy (ESWT)</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Facet Joint Interventions</b>				
<a href="#">L38773 Facet Joint Interventions for Pain Management</a>	<a href="#">A58364 Billing and Coding: Facet Joint Interventions for Pain Management</a>	CGS	KY, OH	KY, OH
<a href="#">L33930 Facet Joint Interventions for Pain Management</a>	<a href="#">A57787 Billing and Coding: Facet Joint Interventions for Pain Management</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L35936 Facet Joint Interventions for Pain Management</a>	<a href="#">A57826 Billing and Coding: Facet Joint Interventions for Pain Management</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38801 Facet Joint Interventions for Pain Management</a>	<a href="#">A58403 Billing and Coding: Facet Joint Interventions for Pain Management</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38803 Facet Joint Interventions for Pain Management</a>	<a href="#">A58405 Billing and Coding: Facet Joint Interventions for Pain Management</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L34892 Facet Joint Interventions for Pain Management</a>	<a href="#">A56670 Billing and Coding: Facet Joint Interventions for Pain Management</a>	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
<a href="#">L38765 Facet Joint Interventions for Pain Management</a>	<a href="#">A58350 Billing and Coding: Facet Joint Interventions for Pain Management</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>Facet Joint Interventions</b>				
<a href="#">L38841 Facet Joint Interventions for Pain Management</a>	<a href="#">A58477 Billing and Coding: Facet Joint Interventions for Pain Management</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
<b>Fluid Jet System</b>				
<a href="#">L38378 Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)</a>	<a href="#">A57926 Billing and Coding: Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH)</a>	CGS	KY, OH	KY, OH
<a href="#">L38726 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58264 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L38367 Fluid Jet System Treatment for LUTS/BPH</a>	<a href="#">A56797 Billing and Coding: Fluid Jet System Treatment for LUTs/BPH</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38705 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58227 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38707 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58229 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38712 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58243 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	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
<a href="#">L38549 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58008 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<a href="#">L38682 Transurethral Waterjet Ablation of the Prostate</a>	<a href="#">A58209 Billing and Coding: Transurethral Waterjet Ablation of the Prostate</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>Implantable Continuous Glucose Monitors</b>				
<a href="#">L38662 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58127 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	CGS	KY, OH	KY, OH
<a href="#">L38664 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58136 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L38623 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58116 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38657 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58133 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38659 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58138 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38617 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58110 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	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
<a href="#">L38743 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58277 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<a href="#">L38686 Implantable Continuous Glucose Monitors (I-CGM)</a>	<a href="#">A58213 Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM)</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
<b>Implantable Miniature Telescope (IMT)</b>				
<a href="#">L33584 Implantable Miniature Telescope (IMT)</a>	<a href="#">A57411 Billing and Coding: Implantable Miniature Telescope (IMT)</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
N/A	<a href="#">A53501 Billing and Coding: Implantable Miniature Telescope (IMT) for Macular Degeneration</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>In Vitro Chemosensitivity &amp; Chemoresistance Assays</b>				
<a href="#">L37628 In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	<a href="#">A56071 Billing and Coding: In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L37630 In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	<a href="#">A56073 Billing and Coding: In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>In Vitro Chemosensitivity &amp; Chemoresistance Assays</b>				
<a href="#">L34554 In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	<a href="#">A56871 Billing and Coding: In Vitro Chemosensitivity &amp; Chemoresistance Assays</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Low-Level Laser Therapy</b>				
<a href="#">L33631 Outpatient Physical and Occupational Therapy Services</a>	<a href="#">A56566 Billing and Coding: Outpatient Physical and Occupational Therapy Services</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<b>Lumbar Artificial Disc Replacement</b>				
<a href="#">L37826 Lumbar Artificial Disc Replacement</a>	<a href="#">A56390 Billing and Coding: Lumbar Artificial Disc Replacement</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS)</b>				
<a href="#">L37790 Magnetic Resonance Guided Focused Ultrasound Surgery System (MRgFUS) for the treatment of neurologic conditions</a>	<a href="#">A58323 Billing and Coding: Magnetic Resonance Guided Focused Ultrasound Surgery System (MRgFUS) for the treatment of neurologic conditions</a>	CGS	KY, OH	KY, OH
<a href="#">L38506 Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</a>	<a href="#">A57884 Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L37421 Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Tremor</a>	<a href="#">A57435 Billing and Coding: Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Tremor</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L37729 Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease</a>	<a href="#">A57512 Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L37738 Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease</a>	<a href="#">A57513 Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38495 Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</a>	<a href="#">A57839 Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor</a>	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
<a href="#">L37761 Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</a>	<a href="#">A56690 Billing and Coding: Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>Micro-Invasive Glaucoma Surgery (MIGS)</b>				
<a href="#">L37578 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A56491 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	CGS	KY, OH	KY, OH
<a href="#">L38233 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A56647 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L37244 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A56588 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L38299 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A57863 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L38301 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A57864 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L38223 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A56633 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	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
<a href="#">L37531 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A56866 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<a href="#">L39620 Micro-Invasive Glaucoma Surgery (MIGS)</a>	<a href="#">A59431 Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)</a>	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
<b>Myocardial Contrast Perfusion Echocardiography</b>				
<a href="#">L38786 Echocardiography for Myocardial Perfusion</a>	<a href="#">A58503 Billing and Coding: Echocardiography for Myocardial Perfusion</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Noncontact Near-Infrared Spectroscopy</b>				
<a href="#">L39385 Near-Infrared Spectroscopy in Wound and Flap Management</a>	<a href="#">A59158 Billing and Coding: Near-Infrared Spectroscopy in Wound and Flap Management</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Platelet Rich Plasma</b>				
<a href="#">L39023 Platelet Rich Plasma Injections for Non-Wound Injections</a>	<a href="#">A58737 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections</a>	CGS	KY, OH	KY, OH
<a href="#">L39071 Platelet Rich Plasma</a>	<a href="#">A58810 Billing and Coding: Platelet Rich Plasma</a>	First Coast	FL, PR, VI	FL, PR, VI

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<b>Platelet Rich Plasma</b>				
<a href="#">L38937 Platelet Rich Plasma</a>	<a href="#">A58609 Billing and Coding: Platelet Rich Plasma</a>	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
<a href="#">L39058 Platelet Rich Plasma Injections for Non-Wound Injections</a>	<a href="#">A58788 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections</a>	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
<a href="#">L39060 Platelet Rich Plasma Injections for Non-Wound Injections</a>	<a href="#">A58790 Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L39068 Platelet Rich Plasma</a>	<a href="#">A58808 Billing and Coding: Platelet Rich Plasma</a>	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
<a href="#">L38745 Platelet Rich Plasma</a>	<a href="#">A58282 Billing and Coding: Platelet Rich Plasma</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Quantitative Sensory Testing (QST)</b>				
<a href="#">L34859 Nerve Conduction Studies and Electromyography</a>	<a href="#">A57123 Billing and Coding: Nerve Conduction Studies and Electromyography</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L35081 Nerve Conduction Studies and Electromyography</a>	<a href="#">A54095 Billing and Coding: Nerve Conduction Studies and Electromyography</a>	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
<b>Scalp Cooling</b>				
<a href="#">L39573 Scalp Cooling for the Prevention of Chemotherapy-Induced Alopecia</a>	<a href="#">A59371 Billing and Coding: Scalp Cooling for the Prevention of Chemotherapy-Induced Alopecia</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
<b>Transanal Endoscopic Surgery (TES)</b>				
<a href="#">L38551 Transanal Endoscopic Surgery (TES)</a>	<a href="#">A58000 Billing and Coding: Transanal Endoscopic Surgery (TES)</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

## 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, Change 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 Policy Guidelines

[Anterior Segment Aqueous Drainage Device](#)

[Coronary Fractional Flow Reserve Using Computed Tomography \(FFR-ct\)](#)

[Ocular Telescope](#)

## 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 Surgical Treatments](#)

[Orthopedic Procedures, Devices, and Products](#)

[Radiation and Oncologic Procedures](#)

[Spine Procedures](#)

[Uterine Services and Procedures](#)

[Vision Services, Therapy, and Rehabilitation](#)

## UnitedHealthcare Commercial Policies

[Autologous Cellular Therapy](#)

[Abnormal Uterine Bleeding and Uterine Fibroids](#)

[Apheresis](#)

[Breast Imaging for Screening and Diagnosing Cancer](#)

[Category III Codes](#)

[Computer-Assisted Surgical Navigation for Musculoskeletal Procedures](#)

[Corneal Hysteresis and Intraocular Pressure Measurement](#)

[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](#)

[Minimally Invasive Spine Surgery Procedures](#)

[Neurophysiologic Testing and Monitoring](#)

[Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds](#)

[Obstructive and Central Sleep Apnea Treatment](#)

[Omnibus Codes](#)

[Prolotherapy and Platelet Rich Plasma Therapies](#)

[Prostate Surgeries and Interventions](#)

[Sacroiliac Joint Interventions](#)

[Spinal Fusion and Decompression](#)

[Surgery of the Knee](#)

[Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins](#)

[Transcatheter Heart Valve Procedures](#)

[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
12/13/2023	<p><b>Policy Summary</b></p> <p><b>Guidelines</b></p> <p><b>Coverage Guidelines</b></p> <ul style="list-style-type: none"> <li>• Added language to indicate:           <ul style="list-style-type: none"> <li><b>Computed Tomography Cerebral Perfusion Analysis (CTP) (CPT Code 0042T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a National Coverage Determination (NCD) and Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist</li> </ul> </li> <li><b>Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure (CPT Codes 0054T and 0055T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> </li> <li><b>Focused Ultrasound Ablation of Uterine Leiomyomata (CPT Codes 0071T and 0072T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Abnormal Uterine Bleeding and Uterine Fibroids</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> </li> <li><b>Transcatheter Placement of Extracranial Vertebral Artery Stent(s) (CPT Codes 0075T and 0076T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> </li> <li><b>Cervical Artificial Disc Replacement (CPT Code 0098T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> </li> <li><b>Retinal Prosthesis (CPT Code 0100T)</b> <ul style="list-style-type: none"> <li>○ 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</li> <li>○ Medicare also understands that both outpatient hospital providers and ASCs (ambulatory surgical centers) are no longer performing the Argus® II implantation procedure</li> <li>○ Refer to the Jul. 2022 CMS Transmittals:               <ul style="list-style-type: none"> <li>▪ <a href="#">11472 [Update of the Ambulatory Surgical Center (ASC) Payment System]</a></li> <li>▪ <a href="#">11457 [Update of the Hospital Outpatient Prospective Payment System (OPPS)]</a></li> </ul> </li> </ul> </li> <li><b>Extracorporeal Shock Wave Involving Musculoskeletal System (CPT Codes 0101T and 0102T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> </li> <li><b>Quantitative Sensory Testing (QST) (CPT Codes 0106T, 0107T, 0108T, 0109T, and 0110T)</b> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Neurophysiologic Testing and Monitoring</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> </li> <li><b>Lumbar Artificial Disc Replacement (CPT Codes 0164T and 0165T)</b> <ul style="list-style-type: none"> <li>○ Lumbar artificial disc replacement (LADR) for the members over 60 years of age is not covered; refer to the NCD for <i>Lumbar Artificial Disc Replacement (LADR) (150.10)</i></li> <li>○ Medicare does not have a NCD for members 60 years of age and younger; coverage</li> </ul> </li> </ul> </li> </ul>

Date	Summary of Changes
	<p>determination is to be made by the local contractor and LCDs/LCAs exist</p> <p><b>Computer Aided Detection (CAD) Systems (CPT Codes 0174T and 0175T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transanal Endoscopic Microsurgery (CPT Code 0184T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Intraocular Pressure Measurement (CPT Codes 0198T and 0329T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Corneal Hysteresis and Intraocular Pressure Measurement</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Percutaneous Sacral Augmentation (Sacroplasty) (CPT Codes 0200T and 0201T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Minimally Invasive Spine Surgery Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Posterior Vertebral Joint(s) Arthroplasty (CPT Code 0202T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Spinal Fusion and Decompression</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Evacuation of Meibomian Glands (CPT Codes 0207T and 0563T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Automated Audiometry (CPT Codes 0208T, 0209T, 02110T, 0211T, and 0212T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Facet Joint Interventions (CPT Codes 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0219T, 0220T, 0221T, and 0222T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist for all states/territories</li> </ul> <p><b>Platelet Rich Plasma (CPT Code 0232T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prolotherapy and Platelet Rich Plasma Therapies</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transluminal Peripheral Atherectomy (CPT Codes 0234T, 0235T, 0236T, 0237T, and 0238T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Anterior Segment Aqueous Drainage Device (CPT Codes 0253T, 0449T, 0450T, 0474T, and 0671T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist; refer to the Medicare Advantage Policy Guideline titled <i>Anterior Segment Aqueous Drainage Device</i></li> </ul> <p><b>Autologous Cellular Therapy (CPT Codes 0263T, 0264T, 0265T, 0489T, 0490T, 0565T, 0566T, 0717T, and 0718T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Autologous Cellular Therapy</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Carotid Sinus Baroreflex Activation Device (CPT Codes 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, and 0273T)</b></p>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Percutaneous Image-Guided Lumbar Decompression (PILD) (CPT Code 0275T)</b></p> <ul style="list-style-type: none"> <li>○ The Centers for Medicare &amp; Medicaid Services (CMS) has determined that PILD will be covered by Medicare under section <i>1862(a)(1)(E) of the Social Security Act</i> through Coverage with Evidence Development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study</li> <li>○ Refer to the NCD for <i>Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (NCD 150.13)</i></li> </ul> <p><b>Scrambler Therapy (CPT Code 0278T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Ocular Telescope (CPT Code 0308T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled <i>Ocular Telescope</i></li> </ul> <p><b>Tear Film Imaging (CPT Code 0330T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Myocardial Sympathetic Innervation Imaging (CPT Codes 0331T and 0332T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Visual Evoked Potential, Screening of Visual Acuity (CPT Code 0333T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Category III Codes</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Sinus Tarsi Implant (CPT Codes 0335T, 0510T and 0511T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Renal Sympathetic Denervation (CPT Codes 0338T and 0339T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Therapeutic Apheresis with Selective HDL Delipidation and Plasma Reinfusion (CPT Code 0342T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Apheresis</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Mitral Valve Repair (CPT Code 0345T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare covers transcatheter edge-to-edge repair (TEER) for mitral valve regurgitation under Coverage with Evidence Development (CED); refer to the NCD for <i>Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (NCD 20.33)</i></li> </ul> <p><b>Radiostereometric Analysis (RSA) (CPT Codes 0347T, 0348T, 0349T, and 0350T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul>

Date	Summary of Changes
	<p><b>Optical Coherence Tomography of Breast (CPT Codes 0351T, 0352T, 0353T, and 0354T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Bioelectrical Impedance Analysis Whole Body Composition Assessment (CPT Code 0358T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>High Dose Rate Electronic Brachytherapy (CPT Codes 0394T and 0395T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Endoscopic Retrograde Cholangiopancreatography (ERCP) with Optical Endomicroscopy (CPT Code 0397T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist for all states/territories</li> </ul> <p><b>Cardiac Contractility Modulation (CPT Codes 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, and 0418T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Destruction of Neurofibroma (CPT Codes 0419T and 0420T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transurethral Waterjet Ablation of Prostate (CPT Code 0421T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist for all states/territories</li> </ul> <p><b>Computer-Aided Tactile Breast Imaging (CPT Code 0422T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Breast Imaging for Screening and Diagnosing Cancer</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Neurostimulator System for Treatment of Central Sleep Apnea (CPT Codes 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Obstructive and Central Sleep Apnea Treatment</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Myocardial Contrast Perfusion Echocardiography (CPT Code 0439T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Percutaneous Cryoablation (CPT Codes 0440T, 0441T, and 0442T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Drug Eluting Ocular Inserts (CPT Codes 0444T and 0445T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Implantable Interstitial Glucose Sensor (CPT Codes 0446T, 0447T, and 0448T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist for all states/territories</li> </ul>

Date	Summary of Changes
	<p><b>Visual Evoked Potential, Testing for Glaucoma (CPT Code 0464T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Neurophysiologic Testing and Monitoring</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Suprachoroidal Injection of a Pharmacologic Agent (CPT Code 0465T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Retinal Polarization Scan (CPT Code 0469T)</b></p> <ul style="list-style-type: none"> <li>○ Retinal polarization scan services have a Status Indicator of ‘N’ (Non-Covered) on the <a href="#">National Physician Fee Schedule</a>; these services are not covered by Medicare</li> </ul> <p><b>Retinal Prosthetic Device Evaluation and Programming (CPT Codes 0472T and 0473T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>White Blood Cell Concentrate Injection (CPT Code 0481T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Category III Codes</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Mitral Valve Implantation/Replacement (TMVI) with Prosthetic Valve (CPT Codes 0483T and 0484T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Transcatheter Heart Valve Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Optical Coherence Tomography (OCT) of Middle Ear (CPT Codes 0485T and 0486T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Surgical Preparation of Cadaver Donor Lung(s) (CPT Codes 0494T and 0495T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Endovenous Femoral-Popliteal Arterial Revascularization (CPT Codes 0505T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Heterochromatic Flicker Photometry (CPT Code 0506T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Near-Infrared Dual Imaging of Meibomian Glands (CPT Code 0507T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Electroretinography (ERG) (CPT Code 0509T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Extracorporeal Shock Wave for Integumentary Wound Healing (CPT Codes 0512T and 0513T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare</li> </ul>

Date	Summary of Changes
	<p>Commercial Medical Policy titled <i>Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds</i> for coverage guidelines for states/territories with no LCDs/LCAs</p> <p><b>Wireless Cardiac Stimulator for Left Ventricular Pacing (CPT Codes 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, and 0522T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Balloon Sclerotherapy (CPT Code 0524T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Intracardiac Ischemia Monitoring Systems (CPT Codes 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, and 0532T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Omnibus Codes</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Movement Disorder Analysis (CPT Codes 0533T, 0534T, 0535T, and 0536T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Neurophysiologic Testing and Monitoring</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Chimeric Antigen Receptor T-cell (CAR-T) Therapy (CPT Codes 0537T, 0538T, 0539T, and 0540T)</b></p> <ul style="list-style-type: none"> <li>○ CMS covers autologous treatment for cancer with T-cells expressing at least one chimeric antigen receptor (CAR) when administered at healthcare facilities enrolled in the FDA risk evaluation and mitigation strategies (REMS) and used for a medically accepted indication as defined at Social Security Act section 1861(t)(2)</li> <li>○ Refer to the NCD for <i>Chimeric Antigen Receptor (CAR) T-cell Therapy (NCD 110.24)</i></li> </ul> <p><b>Magnetocardiography (MCG) (CPT Codes 0541T and 0542T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transapical Mitral Valve Repair (CPT Code 0543T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Transcatheter Heart Valve Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Mitral Valve Annulus Reconstruction (CPT Code 0544T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Transcatheter Heart Valve Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Tricuspid Valve Reconstruction, Repair, Implantation (TTVI) or Replacement (CPT Codes 0545T, 0569T, 0570T, and 0646T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Transcatheter Heart Valve Procedures</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Radiofrequency Spectroscopy (CPT Code 0546T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Bone-Material Quality Testing by Microindentation(s) (CPT Code 0547T)</b></p>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Low Level/Cold Laser Light Therapy (LLLLT) (CPT Code 0552T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Category III Codes</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Iliac Arteriovenous Anastomosis Implant (CPT Code 0553T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Bone Mass Measurement (CPT Codes 0554T, 0555T, 0556T, 0557T, and 0558T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable</li> </ul> <p><b>Three Dimensional (3D) Printed Anatomic Models (CPT Codes 0559T, 0560T, 0561T, and 0562T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Chemotherapeutic Drug Cytotoxicity Assay of Cancer Stem Cells (CSCS) (CPT Code 0564T)</b></p> <ul style="list-style-type: none"> <li>○ Human tumor drug sensitivity assays are considered experimental, and therefore, not covered under Medicare at this time</li> <li>○ Refer to the NCD for Human Tumor Stem Cell Drug Sensitivity Assays (NCD 190.7)</li> <li>○ LCDs/LCAs exist</li> </ul> <p><b>Fallopian Tube Occlusion with a Degradable Biopolymer Implant (CPT Code 0567T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Sonosalpingography (CPT Code 0568T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Implantable Cardioverter-Defibrillator System with Substernal Electrode (CPT Codes 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, and 0614T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Cryoablation of Breast Carcinoma and Fibroadenoma (CPT Code 0581T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>High-Energy Water Vapor Thermotherapy (CPT Code 0582T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prostate Surgeries and Interventions</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Tympanostomy (Requiring Insertion of Ventilating Tube) (CPT Code 0583T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul>



Date	Summary of Changes
	<p><b>Limb Lengthening Procedure (CPT Code 0594T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Female Voiding Prosthesis (CPT Codes 0596T and 0597T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Noncontact Real-Time Fluorescence Wound Imaging (CPT Codes 0598T, and 0599T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Irreversible Electroporation Ablation (CPT Codes 0600T and 0601T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transdermal Glomerular Filtration Rate (GFR) Measurement(s) (CPT Codes 0602T and 0603T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Optical Coherence Tomography (OCT) of Retina (CPT Codes 0604T, 0605T, and 0606T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Remote Monitoring of Pulmonary System (CPT Codes 0607T and 0608T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Magnetic Resonance Spectroscopy (CPT Codes 0609T, 0610T, 0611T, and 0612T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Interatrial Septal Shunt Device Implantation (CPT Code 0613T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Eye-Movement Analysis without Spatial Calibration (CPT Code 0615T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Iris Prosthesis Insertion (CPT Codes 0616T, 0617T, and 0618T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Cystourethroscopy with Transurethral Anterior Prostate Commissurotomy (CPT Code 0619T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul>

Date	Summary of Changes
	<p><b>Endovascular Venous Arterialization (CPT Code 0620T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Trabeculostomy Procedure by Laser (Ab Interno) (CPT Codes 0621T and 0622T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Automated Analysis of Coronary Atherosclerotic Plaque (CPT Codes 0623T, 0624T, 0625T, and 0626T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Percutaneous Injection of Allogeneic Cellular/Tissue-Based Products (CPT Codes 0627T, 0628T, 0629T, and 0630T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Discogenic Pain Treatment</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Hyperspectral Imaging (CPT Code 0631T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Ultrasound Nerve Ablation (CPT Code 0632T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Computed Tomography of the Breast (CPT Codes 0633T, 0634T, 0635T, 0636T, 0637T, and 0638T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Breast Imaging for Screening and Diagnosing Cancer</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Cerebrospinal Fluid Shunt Analysis (CPT Code 0639T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Non-Contact Near-Infrared Spectroscopy (NIRS) (CPT Codes 0640T, 0641T, and 0642T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD</li> <li>○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the UnitedHealthcare Commercial Medical Policies titled <i>Omnibus Codes</i> for coverage guidelines, for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Implantation and Removal Procedures (CPT Codes 0643T, 0644T, and 0645T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Magnetic Gastropexy with Gastrostomy Tube Insertion (CPT Code 0647T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Quantitative Magnetic Resonance Tissue Composition Analysis (CPT Codes 0648T and 0649T)</b></p>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Magnetically Controlled Capsule Endoscopy (CPT Code 0651T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Esophagogastroduodenoscopy (CPT Code 0652T, 0653T, and 0654T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Transperineal Focal Laser Ablation (CPT Code 0655T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prostate Surgeries and Interventions</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Vertebral Body Tethering (CPT Code 0656T and 0657T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Vertebral Body Tethering for Scoliosis</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Electrical Impedance Spectroscopy for Automated Melanoma Risk Score (CPT Code 0658T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Intracoronary Infusion of Supersaturated Oxygen (CPT Code 0659T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Drug-Eluting Implant Procedures in Eye (CPT Codes 0660T and 0661T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Scalp Cooling (CPT Codes 0662T and 0663T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Donor Hysterectomy (CPT Codes 0664T, 0665T, 0666T, and 0667T)</b></p> <ul style="list-style-type: none"> <li>○ Donor hysterectomy services have a Status Indicator of 'N' (Non-Covered) on the <a href="#">National Physician Fee Schedule</a>; these services are not covered by Medicare</li> </ul> <p><b>Uterus Transplantation (CPT Codes 0668T, 0669T, and 0670T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Cryogen-Cooled Monopolar Radiofrequency (CMRF) (CPT Code 0672T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Benign Thyroid Nodule Ablation (CPT Code 0673T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Diaphragmatic Stimulation System (CPT Codes 0674T, 0675T, 0677T, 0679T, 0680T, 0681T, 0682T, 0683T, 0684T, and 0685T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for</li> </ul>

Date	Summary of Changes
	<p>states/territories with no LCDs/LCAs</p> <p><b>Malignant Hepatocellular Histotripsy (CPT Code 0686T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Remote, Online and/or Digital Therapy for Amblyopia (CPT Codes 0687T, 0688T, 0704T, 0705T, and 0706T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Visual Information Processing Evaluation and Orthoptic and Vision Therapy</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Quantitative Ultrasound Tissue Characterization (CPT Code 0689T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Automated Analysis of Vertebral Fracture (CPT Code 0691T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Aquapheresis (Ultrafiltration) (CPT Code 0692T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Vertebral Motion Analysis (CPT Code 0693T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Three-Dimensional Imaging and Reconstruction of Breast or Axillary Lymph Node Tissue (CPT Code 0694T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Mapping of Pacemaker or Pacing Cardioverter-Defibrillator Lead(s) (CPT Codes 0695T and 0696T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Posterior Chamber Injection (CPT Code 0699T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Molecular Fluorescent Imaging of Suspicious Nevus (CPT Code 0700T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Subchondral Bone Defect Injection (CPT Code 0707T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Intradermal Immunotherapy (CPT Code 0708T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for</li> </ul>

Date	Summary of Changes
	<p>states/territories with no LCDs/LCAs</p> <p><b>Noninvasive Arterial Plaque Analysis (CPT Codes 0710T, 0711T, 0712T, and 0713T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transperineal Laser Ablation (TPLA) (CPT Code 0714T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prostate Surgeries and Interventions</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Coronary Artery Disease (CAD) Risk Score Analysis (CPT Code 0716T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Posterior Lumbar Vertebral Joint Replacement (CPT Code 0719T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Spinal Fusion and Decompression</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Percutaneous Electrical Nerve Field Stimulation (PENFS) (CPT Code 0720T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Tissue Characterization by Quantitative Computed Tomography (CPT Code 0721T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) (CPT Code 0723T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Vestibular Device Procedures (CPT Codes 0725T, 0726T, 0727T, 0728T, and 0729T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>AI-Based Facial Phenotype Analysis (CPT Code 0731T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Immunotherapy Administration with Electroporation (CPT Code 0732T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Remote Body and Limb Kinematic Measurement-Based Therapy (CPT Codes 0733T and 0734T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Colonic Lavage with Insertion of Rectal Catheter (CPT Code 0736T)</b></p> <ul style="list-style-type: none"> <li>○ 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 <i>1862(a)(1) of the Act</i></li> </ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>○ Refer to the NCD for <i>Colonic Irrigation (NCD 100.7)</i></li> </ul> <p><b>Xenograft Implantation (CPT Code 0737T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Surgery of the Knee</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Prostate Tissue Ablation by Magnetic Field Induction (CPT Codes 0738T and 0739T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prostate Surgeries and Interventions</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Remote Insulin Dose Calculation and Monitoring System (CPT Codes 0740T and 0741T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Absolute Quantitation of Myocardial Blood Flow (AQMBF) (CPT Code 0742T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs exist</li> </ul> <p><b>Bone Strength and Fracture-Risk Assessment (CPT Codes 0743T, 0749T, and 0750T)</b></p> <ul style="list-style-type: none"> <li>○ Bone strength and fracture-risk assessment services have a Status Indicator of 'N' (Non-Covered) on the <a href="#">National Physician Fee Schedule</a>; these services are not covered by Medicare</li> </ul> <p><b>Bioprosthetic Valve Insertion (CPT Code 0744T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Cardiac Radioablation (CPT Codes 0745T, 0746T, and 0747T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Stem Cell Injection for Perianal Fistula (CPT Code 0748T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Risk-Based Assessment for Cardiac Dysfunction (CPT Code 0765T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcutaneous Magnetic Stimulation (tMS) (CPT Codes 0766T, 0767T, 0768T, and 0769T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Virtual Reality Technology Services (CPT Codes 0771T and 0773T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Sacroiliac Joint Arthrodesis (CPT Codes 0775T and 0809T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Sacroiliac Joint Interventions</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Intra-Brain Hypothermia Induction (CPT Code 0776T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul>

Date	Summary of Changes
	<p><b>Surface Mechanomyography (sMMG) (CPT Code 0778T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Neurophysiologic Testing and Monitoring</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Gastrointestinal Myoelectrical Activity Study (CPT Code 0779T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Gastrointestinal Motility Disorders, Diagnosis and Treatment</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Bronchoscopy with Radiofrequency Destruction of the Pulmonary Nerves (CPT Codes 0781T and 0782T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcutaneous Auricular Neurostimulation (tAN) (CPT Code 0783T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Virtual Reality-Facilitated Gait Training (CPT Code 0791T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Silver Diamine Fluoride for Dental Caries (CPT Code 0792T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Transcatheter Thermal Nerve Ablation with Catheterization and Angiography (CPT Code 0793T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Pharmaco-Oncologic Treatment Planning (CPT Code 0794T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Permanent Dual-Chamber Leadless Pacemaker (CPT Codes 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, and 0804T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare covers leadless pacemakers through Coverage with Evidence Development (CED); refer to the NCD for <i>Leadless Pacemakers (NCD 20.8.4)</i></li> </ul> <p><b>Caval Valve Implantation (CAVI) (CPT Codes 0805T and 0806T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Pulmonary Tissue Ventilation Analysis (CPT Codes 0807T and 0808T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Subretinal Injection with Vitrectomy and Retinotomies (CPT Code 0810T)</b></p> <ul style="list-style-type: none"> <li>○ Medicare does not have a NCD and LCDs/LCAs do not exist; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Category III Codes</i> for coverage guidelines for states/territories with no LCDs/LCAs</li> </ul> <p><b>Applicable Codes</b></p>

Date	Summary of Changes
	<p><b>CPT Codes</b></p> <p><b>Non-Covered</b></p> <ul style="list-style-type: none"> <li>• Added notation to indicate: <ul style="list-style-type: none"> <li>○ 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, 0436T, 0465T, 0479T, 0480T, 0533T, 0534T, 0535T, 0536T, 0584T, 0585T, 0586T, 0641T, 0642T, 0768T, 0769T, 0775T, and 0809T were “deleted Dec. 31, 2023”</li> <li>○ 0488T, 0591T, 0592T, and 0593T were “deleted Dec. 31, 2022”</li> </ul> </li> <li>• Removed 0423T, 0662T, 0671T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, and 0804T</li> <li>• Removed instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled <i>Human Tumor Stem Cell Drug Sensitivity Assays (NCD 190.7)</i> for 0564T</li> <li>• Revised description for 0517T, 0518T, 0519T, 0520T, 0640T, 0656T, 0657T, 0766T, and 0767T</li> </ul> <p><b>Provisional Coverage</b></p> <ul style="list-style-type: none"> <li>• Added 0164T, 0165T, 0394T, 0395T, 0537T, 0538T, 0539T, 0540T, 0662T, 0663T, 0671T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, and 0804T</li> <li>• Added notation to indicate 0501T, 0502T, 0503T, 0504T, and 0508T were “deleted Dec. 31, 2023”</li> <li>• Removed 0191T, 0355T, 0376T, 0466T, 0467T, 0468T, 0548T, 0549T, 0550T, and 0551T</li> <li>• Removed list of applicable codes: 0163T, 0164T, 0165T, 0356T, 0394T, 0395T, 0537T, 0538T, 0539T, 0540T, and 0571T</li> <li>• Removed instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled <i>[Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (NCD 20.33)]</i> for 0345T</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Updated <i>References</i> section to reflect the most current information</li> <li>• Modified <i>Purpose</i> section; added language to indicate: <ul style="list-style-type: none"> <li>○ UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage</li> <li>○ 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 <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ 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</li> </ul> </li> </ul> </li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>• Archived previous policy version MPG043.36</li> </ul>

## 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](#).