Local Coverage Determination (LCD): Non-Covered Services (L36219)

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**Contractor Information**

<table>
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<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
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<td>01111 - MAC A</td>
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<td>California - Entire State</td>
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**LCD Information**

**Document Information**

- Original Effective Date: For services performed on or after 10/01/2015
- Revision Effective Date: For services performed on or after 01/01/2018
- Revision Ending Date: N/A
- Retirement Date: N/A
- Notice Period Start Date: N/A
- Notice Period End Date: N/A

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• 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 in the particular case.
• 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 (such as inpatient care at a hospital or SNF, outpatient care through a hospital or physicians office or home care) appropriate to the patients medical needs and condition.

To be considered medically necessary, items and services must have been established as safe and effective. That is, the items and services must be:

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

Medicare is a defined benefit program; contractors sometimes have to decide whether a service fits one of the defined benefits categories. Services that this contractor considers non-covered because the service does not fit into a benefit category are also included on this list.

A service or procedure on the national non-coverage list may be non-covered for a variety of reasons. It may be non-covered based on a specific exclusion contained in the Medicare law (for example, acupuncture) it may be viewed as not yet proven safe and effective and, therefore, not medically reasonable and necessary; or it may be a procedure that is always considered cosmetic in nature and is denied on that basis. The precise basis for a national decision to non-cover a procedure may be found in the references cited in this policy. These national non-covered services are listed in this LCD for informational purposes only.

A service or procedure on the local list is always denied on the basis that Noridian does not believe it is ever medically reasonable and necessary. The Noridian list of LCD exclusions contains procedures that, for example, are:

• Experimental.
• Not proven safe and effective.

Or,

• Not approved by the FDA.

Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not considered reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures and services performed using devices that have not been approved for marketing by the FDA or for those not included in an FDA-approved investigational (IDE) trial.

If a test, treatment or procedure is neither specifically covered nor excluded in Medicare law or guidelines, carriers must make a coverage determination that is based upon the general acceptance of the test, treatment or procedure by the professional medical community as an effective and proven treatment for the condition for which it is being used. Medicare will make payment only when a service is accepted as effective and proven. Some tests or services are obsolete and have been replaced by more advanced procedures. The tests or procedures may be paid only if the physician who performs them satisfactorily justifies the medical need for the procedure(s).

“When processing a claim, carriers continue to determine if a service is reasonable and necessary to treat illness or injury. If a service is not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), carriers consider the service noncovered notwithstanding the presence of a payment amount for the service in the Medicare fee schedule. The presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare. The nature of the status indicator in the database does not control coverage except where the status is N for noncovered.” [Medicare Claims Processing Manual (CMS Pub. 100-04, Chapter 23, Section 30 A)]

It is important to note that the fact that a new service or procedure has been issued a CPT code or is FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary. Noridian evaluates new services, procedures, drugs or technology and considers national and local policies before these new services may be considered Medicare covered services.
This LCD contains listings of numerous non-covered services which have no specific CPT code. Adding difficulty to correct coding for such services is the fact that there are many where two or more specific unlisted codes could arguably be used to designate the service. Initial preparation of the LCD to cover every possible code use – and more importantly, maintenance of the LCD as code changes occur – is difficult if not impossible.

**Therefore**, providers must bear in mind that **any** service that is described in any Noridian LCD as “non-covered” will remain non-covered no matter which CPT code is selected for billing. Since many of the unlisted codes, however, are also correctly used for billing of **covered** services, it is likely that prepay denial edits cannot be implemented into the claims processing computer system. Because of this, clearly non-covered services can in some instances be paid. Providers are reminded that these paid services will be subject to recoupment by Noridian, as well as other review contractors, including the Recovery Audit Contractors (RACs).

Services that this contractor considers a component of another service and never separately billable or payable are also included here unless those services are already included in the mutually exclusive Correct Coding edits. For some services one or more of the Medicare payment systems (for example, the Physician Fee Schedule or the Outpatient Prospective Payment System) may indicate that the service is bundled or packaged or not paid for some other reason, in which case those indicators take precedence over the placement in this policy.

This is not an all-inclusive list of services not covered or not paid separately by Medicare.

**If you disagree with some aspects of a final LCD, you have the option of submitting a formal reconsideration to Noridian Medicare Part B. See www.noridianmedicare.com for the reconsideration process. This reconsideration must be accompanied by complete copies of relevant peer-reviewed literature that support the recommendation. Abstracts are not sufficient for this purpose. Keep in mind that no change will be made that will put the LCD in conflict with CMS regulations.**

Removal of a service from this policy does not imply that the service is always covered. The service must meet Medicare coverage criteria and the documentation in the medical record must support the service as billed.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

**Summary of Evidence**

N/A

**Analysis of Evidence**

(Rationale for Determination)

N/A

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**Coding Information**

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally printed on 2/8/2018. Page 4 of 23
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

025X Pharmacy - General Classification
026X IV Therapy - General Classification
027X Medical/Surgical Supplies and Devices - General Classification
030X Laboratory - General Classification
031X Laboratory Pathology - General Classification
032X Radiology - Diagnostic - General Classification
033X Radiology - Therapeutic and/or Chemotherapy Administration - General Classification
034X Nuclear Medicine - General Classification
035X CT Scan - General Classification
036X Operating Room Services - General Classification
037X Anesthesia - General Classification
040X Other Imaging Services - General Classification
041X Respiratory Services - General Classification
042X Physical Therapy - General Classification
043X Occupational Therapy - General Classification
044X Speech-Language Pathology - General Classification
045X Emergency Room - General Classification
046X Pulmonary Function - General Classification
048X Cardiology - General Classification
049X Ambulatory Surgical Care - General Classification
050X Outpatient Services - General Classification
051X Clinic - General Classification
052X Freestanding Clinic - General Classification
055X Skilled Nursing - General Classification
0610 Magnetic Resonance Technology (MRT) - General Classification
0619 Magnetic Resonance Technology (MRT) - Other MRT
0621 Medical/Surgical Supplies and Devices - Supplies Incident to Radiology
0622 Medical/Surgical Supplies and Devices - Supplies Incident to Other DX Services
0623 Medical/Surgical Supplies and Devices - Surgical Dressings
0624 Medical/Surgical Supplies and Devices - FDA Investigational Devices
0631 Pharmacy - Single Source Drug
0632 Pharmacy - Multiple Source Drug
0633 Pharmacy - Restrictive Prescription
0636 Pharmacy - Drugs Requiring Detailed Coding
073X EKG/ECG (Electrocardiogram) - General Classification
CPT/HCPCS Codes

**Group 1 Paragraph:**

**Noridian Non-Coverage Determinations:**

**Note:** These lists of non-covered services are not all-inclusive:

Services that are not covered due to being investigational/experimental, not proven effective or are not reasonable and necessary:

To bill the patient for procedures and services that are not covered for these reasons will generally require an Advance Beneficiary Notice (ABN) to be obtained before the service is rendered.

All new Category III Codes, unless specifically approved for payment by CMS or the Noridian Medical Directors and listed as approved in our article, are non-covered. In most cases, in accordance with the CPT Manual, these codes have been created to track new, "emerging" unproven therapies and tests. If a provider or other interested party believes that a service described by a Category III code or any other code in this policy is medically reasonable and necessary, the provider or party should submit the peer-reviewed medical literature, supporting the safety and effectiveness of the service for Medical Director review. This request for coverage of the service may be made through the Noridian LCD Reconsideration Process.

**Group 1 - Not Proven Effective, Not Medically Reasonable and Necessary**

**Note:** The following services, as described below and billed with any CPT and or HCPCS code, are considered not proven effective or not medically reasonable and necessary and will be denied as such:

Claims for these services will always be reviewed when they are billed with an unlisted procedure code.

- Accu-Spina
- Analysis of patient-specific findings with quantifiable computer probability assessment, including report
- Antiprothrombin (phospholipid cofactor) antibody, each IG class
- Bile duct extracorporeal shock-wave lithotripsy
- Breast ductoscopy
- BSGI, Breast Scintography
- Carbon monoxide, expired gas analysis [eg. ETCO/hemolysis breath test]
- Circular boot treatment
- Clinical drug interaction testing
- Coblation debridement of tendon and/or fascia
- CT fusion
- Decision DX-LEA Test
- Destruction of macular drusen, photocoagulation
- Electrical impedance breast scan
- Flicker Fusion
- Food scratch test
- Gel platelet application
- Head shaking test
- Heidelberg Gastric Analysis Test
- Hydrotherapy treatments (also known as hydromassage & hydromodality)
- Hypertonic sinus irrigation
- Inert gas rebreathing for cardiac output measurement; during rest
- Inert gas rebreathing for cardiac output measurement; during exercise
- Laser myringectomy
- Laser treatment or low light laser therapy; of rotator cuff tendonitis, to stimulate circulation, for pain and inflammation, for low level laser treatment including, but not limited to trigger points, knees, hips and other joints
- Leukocytes, stool
- Lipoprotein, direct measurement, intermediate density lipoproteins [IDL][remnant lipoprotein]
- Lung spectroscopy

• Mammary duct(s) catheter lavage
• Microvas Treatments for all indications other than those allowed by NCD
• Microdose therapy for arthritis or fibromyalgia
• Microwave phased array thermotherapy for destruction/reduction of malignant breast tumor
• M.O.S.T. protocol (Mental office-based stress test)
• Neuroform® Stent placement for ischemic disease
• Palate implant procedure (Pillar System)
• Percutaneous neuromodulation therapy
• PFL CO monitor
• Phonophoresis
• Platelet plasma mixed with laminate, protein bone growth stimulator
• Platelet rich plasma injection for osteoarthrosis
• Provocation and Neutralization Allergy Testing
• Pulsed magnetic neuromodulation incontinence treatment
• Pulsed radiofrequency treatment
• Qcare
• Reconstruction of iliac bone or crest
• Rhinophototherapy, intranasal application of ultraviolet and visible light
• Saccades eye test or Saccadic eye test
• Secca® procedure
• Sonorex treatment
• Speculoscopy, including sampling
• Splint mouth guard or night guard
• Sublingual antigen drops
• Suprachoroidal delivery of pharmacologic agent
• Therabite appliance dispensed due to trismus
• Therapy using Superluminous Diodes
• Transmyocardial transcatheter closure of ventricular septal defect, with implant, including cardiopulmonary bypass if performed
• Ultrafiltration in heart failure
• Urinalysis infectious agent detection, semi quantitative analysis of volatile compounds
• Vagal nerve stimulation for depression
• von Willebrand Propetide Ag

Additional non-covered CPT codes:

* NOTE: NCD 150.10 prohibits payment for individuals over 60 years of age for the following CPT/HCPCS codes: 22857, 22862, 0098T, 0163T and 0165T. Noridian has also determined these codes do not meet medically necessary criteria for individuals under 60 years of age.

Group 1 Codes:

22857 TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR
22862 REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR
28446 OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT[S])
32998 ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE PULMONARY TUMOR(S)
32998 INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUtaneous, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL; RADIOfrequency ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DELIVERY OF THERMAL ENERGY TO
43257 THE MUSCLE OF LOWER ESOPHAGIAL SPHINCTER AND/OR GASTRIC CARDIA, FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
43284 SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF
43285 REMOVAL OF ESOPHAGIAL SPHINCTER AUGMENTATION DEVICE
46707 REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])
62263 PERCUtaneous lYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 2 OR MORE DAYS
62264 PERCUtaneous lYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 1 DAY

DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, ANY METHOD UTILIZING NEEDLE BASED TECHNIQUE TO REMOVE DISC MATERIAL UNDER FLUOROSCOPIC IMAGING OR OTHER FORM OF INDIRECT VISUALIZATION, WITH DISCOGRAPHY AND/OR EPIDURAL INJECTION(S) AT THE TREATED LEVEL(S), WHEN PERFORMED, SINGLE OR MULTIPLE LEVELS, LUMBAR

83987 PH; EXHALED BREATH CONDENSATE
84145 PROCALCITONIN (PCT)
84431 THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE
86305 HUMAN EPIDIDYMIS PROTEIN 4 (HE4)
91132 ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS;
91133 ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS; WITH PROVOCATIVE TESTING
92145 CORNEAL HYSTEREISIS DETERMINATION, BY AIR IMPULSE STIMULATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
93702 BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)
97026 APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
97033 APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
J2010 INJECTION, LINCOMYCIN HCL, UP TO 300 MG
J7330 AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT
CEREBRAL PERFUSION ANALYSIS USING COMPUTED TOMOGRAPHY WITH CONTRAST ADMINISTRATION,
0042T INCLUDING POST-PROCESSING OF PARAMETRIC MAPS WITH DETERMINATION OF CEREBRAL BLOOD FLOW, CEREBRAL BLOOD VOLUME, AND MEAN TRANSIT TIME
COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH
0054T IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH
0055T IMAGE-GUIDENCE BASED ON CT/MRI IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
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
REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR
0098T APPROACH, EACH ADDITIONAL INTERSPACE, LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0100T PLACEMENT OF A SUBCONJUNCTIVAL RETINAL PROSTHESIS RECEIVER AND PULSE GENERATOR, AND IMPLANTATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY, WITH VITRECTOMY
0101T EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED, HIGH ENERGY
0102T EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN, REQUIRING ANESTHESIA OTHER THAN LOCAL, 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
0111T LONG-CHAIN (C20-22) OMEGA-3 FATTY ACIDS IN RED BLOOD CELL (RBC) MEMBRANES
0113T TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), 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)
0190T PLACEMENT OF INTRAOCULAR RADIATION SOURCE APPLICATOR (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)
ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, DISC SPACE PREPARATION, DISCECTOMY,
0195T WITHOUT INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED; L5-S1 INTERSPACE
0196T ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, DISC SPACE PREPARATION, DISCECTOMY, WITHOUT INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED; L4-L5 INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0198T MEASUREMENT OF OCULAR BLOOD FLOW BY REPETITIVE INTRAOCULAR PRESSURE SAMPLING, WITH INTERPRETATION AND REPORT

0202T POSTERIOR VERTEBRAL JOINT(S) ARTHROPLASTY (EG, FACET JOINT(S) REPLACEMENT), INCLUDING FACETECTOMY, LAMINECTOMY, FORAMINOTOMY, AND VERTEBRAL COLUMN FIXATION, INJECTION OF BONE CEMENT, WHEN PERFORMED, INCLUDING FLUOROSCOPY, SINGLE LEVEL, LUMBAR SPINE INTRAVASCULAR CATHETER-BASED CORONARY VESSEL OR GRAFT SPECTROSCOPY (EG, INFRARED) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT, EACH VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0205T COMPUTERIZED DATABASE ANALYSIS OF MULTIPLE CYCLES OF DIGITIZED CARDIAC ELECTRICAL DATA FROM TWO OR MORE ECG LEADS, INCLUDING TRANSMISSION TO A REMOTE CENTER, APPLICATION OF MULTIPLE NONLINEAR MATHEMATICAL TRANSFORMATIONS, WITH CORONARY ARTERY OBSTRUCTION SEVERITY ASSESSMENT

0207T EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL

0219T PLACEMENT OF A 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 A 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 A 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 A 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)

0224T INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED

0232T TRANSLUMINAL PERIPHERAL ATERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; RENAL ARTERY

0234T TRANSLUMINAL PERIPHERAL ATERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; VISCERAL ARTERY (EXCEPT RENAL), EACH VESSEL

0236T TRANSLUMINAL PERIPHERAL ATERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ABDOMINAL AORTA

0238T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE

0239T ENDOVASCULAR REPAIR OF ILIAC ARTERY BIFURCATION (EG, ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA, DISSECTION) USING BIFURCATED ENDOGRAFT FROM THE COMMON ILIAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL ILIAC ARTERY, INCLUDING ALL SELECTIVE AND/OR NONSELECTIVE CATHETERIZATION(S) REQUIRED FOR DEVICE PLACEMENT AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, UNILATERAL

0240T 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

0241T 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

0242T 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

0243T IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; TOTAL SYSTEM (INCLUDES GENERATOR PLACEMENT, UNILATERAL OR BILATERAL LEAD PLACEMENT, INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)

0244T IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; LEAD ONLY, UNILATERAL (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 (EG, BATTERY STATUS, LEAD IMPEDANCE, PULSE AMPLITUDE, PULSE WIDTH, THERAPY FREQUENCY, PATHWAY MODE, BURST MODE, THERAPY START/STOP TIMES EACH DAY); 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 (EG, BATTERY STATUS, LEAD IMPEDANCE, PULSE AMPLITUDE, PULSE WIDTH, THERAPY FREQUENCY, PATHWAY MODE, BURST MODE, THERAPY START/STOP TIMES EACH DAY); WITH PROGRAMMING

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 (EG, BATTERY STATUS, LEAD IMPEDANCE, PULSE AMPLITUDE, PULSE WIDTH, THERAPY FREQUENCY, PATHWAY MODE, BURST MODE, THERAPY START/STOP TIMES EACH DAY); WITH PROGRAMMING

0274T  PERCUTANEOUS LAMINOTOMY/LAMINECTOMY (INTERLAMINAR APPROACH) FOR DECOMPRESSION OF NEURAL ELEMENTS, (WITH OR WITHOUT LIGAMENTOUS RESECTION, DISCECTOMY, FACETECTOMY AND/OR FORAMINOTOMY), ANY METHOD, UNDER INDIRECT IMAGE GUIDANCE (EG, FLUOROSCOPIC, CT), SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; CERVICAL OR THORACIC

0278T  TRANSCUTANEOUS ELECTRICAL MODULATION PAIN REPROCESSING (EG, SCRAMBLER THERAPY), EACH TREATMENT SESSION (INCLUDES PLACEMENT OF ELECTRODES)

0290T  CORNEAL INCISIONS IN THE RECIPIENT CORNEA CREATED USING A LASER, IN PREPARATION FOR PENETRATING OR LAMELLAR KERATOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0312T  VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, ANTERIOR AND POSTERIOR VAGAL TRUNKS ADJACENT TO ESOPHAGOSTRONGJUNCTION (EGJ), WITH IMPLANTATION OF PULSE GENERATOR, INCLUDES PROGRAMMING

0313T  VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC REVISION OR REPLACEMENT OF VAGAL TRUNK NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR

0316T  VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); REPLACEMENT OF PULSE GENERATOR

0317T  VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); NEUROSTIMULATOR PULSE GENERATOR ELECTRONIC ANALYSIS, INCLUDES REPROGRAMMING WHEN PERFORMED

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  EXTRA-OSSEOUS SUBTALAR JOINT IMPLANT FOR TALOTARSAL STABILIZATION ENDOTHELIAL FUNCTION ASSESSMENT, USING PERIPHERAL VASCULAR RESPONSE TO REACTIVE HYPEREMIA, NON-INVASIVE (EG, BRACHIAL ARTERY ULTRASOUND, PERIPHERAL ARTERY TONOMETRY), UNILATERAL OR BILATERAL

0337T  HYPEREMIA, NON-INVASIVE (EG, BRACHIAL ARTERY ULTRASOUND, PERIPHERAL ARTERY TONOMETRY), UNILATERAL OR BILATERAL

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

0341T  QUANTITATIVE PUPILLOMETRY WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL

0342T  THERAPEUTIC APHERESIS WITH SELECTIVE HDL DELIPIDATION AND PLASMA REINFUSION

0346T  ULTRASOUND, ELASTOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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

0355T GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), COLON, WITH INTERPRETATION AND REPORT

0356T INSERTION OF DRUG-ELUTING IMPLANT (INCLUDING PUNCTAL DILATION AND IMPLANT REMOVAL WHEN PERFORMED) INTO LACRIMAL CANALICULUS, EACH

0357T CRYOPRESERVATION; IMMATURE OOCYTE(S)

0358T BIOELECTRICAL IMPEDANCE ANALYSIS WHOLE BODY COMPOSITION ASSESSMENT, WITH INTERPRETATION AND REPORT

0359T BEHAVIOR IDENTIFICATION ASSESSMENT, BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH PATIENT AND CAREGIVER(S), INCLUDES ADMINISTRATION OF STANDARDIZED AND NON-STANDARDIZED TESTS, DETAILED BEHAVIORAL HISTORY, PATIENT OBSERVATION AND CAREGIVER INTERVIEW, INTERPRETATION OF TEST RESULTS, DISCUSSION OF FINDINGS AND RECOMMENDATIONS WITH THE PRIMARY GUARDIAN(S)/CAREGIVER(S), AND PREPARATION OF REPORT

0360T OBSERVATIONAL BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL DIRECTION WITH INTERPRETATION AND REPORT, ADMINISTERED BY ONE TECHNICIAN; FIRST 30 MINUTES OF TECHNICIAN TIME, FACE-TO-FACE WITH THE PATIENT

0361T OBSERVATIONAL BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL DIRECTION WITH INTERPRETATION AND REPORT, ADMINISTERED BY ONE TECHNICIAN; EACH ADDITIONAL 30 MINUTES OF TECHNICIAN TIME, FACE-TO-FACE WITH THE PATIENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)

0362T EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL DIRECTION WITH INTERPRETATION AND REPORT, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH THE ASSISTANCE OF ONE OR MORE TECHNICIANS; FIRST 30 MINUTES OF TECHNICIAN(S) TIME, FACE-TO-FACE WITH THE PATIENT

0363T EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH THE ASSISTANCE OF ONE OR MORE TECHNICIANS; EACH ADDITIONAL 30 MINUTES OF TECHNICIAN(S) TIME, FACE-TO-FACE WITH THE PATIENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0364T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN, FACE-TO-FACE WITH ONE PATIENT; FIRST 30 MINUTES OF TECHNICIAN TIME

0365T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN, FACE-TO-FACE WITH ONE PATIENT; EACH ADDITIONAL 30 MINUTES OF TECHNICIAN TIME (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0366T GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN, FACE-TO-FACE WITH TWO OR MORE PATIENTS; FIRST 30 MINUTES OF TECHNICIAN TIME

0367T GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN, FACE-TO-FACE WITH TWO OR MORE PATIENTS; EACH ADDITIONAL 30 MINUTES OF TECHNICIAN TIME (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0368T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH ONE PATIENT; FIRST 30 MINUTES OF PATIENT FACE-TO-FACE TIME

0369T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH ONE PATIENT; EACH ADDITIONAL 30 MINUTES OF PATIENT FACE-TO-FACE TIME (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0370T FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITHOUT THE PATIENT PRESENT)

0371T MULTIPLE-FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITHOUT THE PATIENT PRESENT)

0372T ADAPTIVE BEHAVIOR TREATMENT SOCIAL SKILLS GROUP, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL FACE-TO-FACE WITH MULTIPLE PATIENTS

0373T EXPOSURE ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION REQUIRING TWO OR MORE TECHNICIANS; FIRST 60 MINUTES OF TECHNICIANS' TIME, FACE-TO-FACE WITH PATIENT

0374T
EXPOSURE ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION REQUIRING TWO OR MORE TECHNICIANS FOR SEVERE MALADAPTIVE BEHAVIOR(S); EACH ADDITIONAL 30 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH PATIENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**0375T**
END PLATE PREPARATION (INCLUDES OSTEOPHYCTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), CERVICAL, THREE OR MORE LEVELS

INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE TRABECULAR MESHWORK; EACH ADDITIONAL DEVICE INSERTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**0381T**
EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING UP TO 14 DAYS TO ASSESS CHANGES IN HEART RATE AND TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING FROM 15 TO 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REVIEW AND INTERPRETATION ONLY

**0383T**
EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING MORE THAN 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REVIEW AND INTERPRETATION ONLY

**0396T**
INTRA-OPERATIVE USE OF KINETIC BALANCE SENSOR FOR IMPLANT STABILITY DURING KNEE REPLACEMENT ARTHROPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**0397T**
ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP), WITH OPTICAL ENDOMICROSCOPY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**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

**0400T**
MULTI-SPECTRAL DIGITAL SKIN LESION ANALYSIS OF CLINICALLY ATYPICAL CUTANEOUS PIGMENTED LESIONS FOR DETECTION OF MELANOMAS AND HIGH RISK MELANOCYTIC ATYPIA; ONE TO FIVE LESIONS

**0401T**
MULTI-SPECTRAL DIGITAL SKIN LESION ANALYSIS OF CLINICALLY ATYPICAL CUTANEOUS PIGMENTED LESIONS FOR DETECTION OF MELANOMAS AND HIGH RISK MELANOCYTIC ATYPIA; SIX OR MORE LESIONS

**0402T**
COLLAGEN CROSS-LINKING OF CORNEA (INCLUDING REMOVAL OF THE CORNEAL EPITHELIUM AND INTRAOPERATIVE PACHYMETRY WHEN PERFORMED)

**0406T**
NASAL ENDOSCOPY, SURGICAL, ETHMOID SINUS, PLACEMENT OF DRUG ELUTING IMPLANT;

**0407T**
NASAL ENDOSCOPY, SURGICAL, ETHMOID SINUS, PLACEMENT OF DRUG ELUTING IMPLANT; WITH BIOPSY, POLYPECTOMY OR DEBRIDEMENT

**0408T**
INSERTION OR REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM, INCLUDING CONTRACTILITY EVALUATION WHEN PERFORMED, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; PULSE GENERATOR WITH TRANSVENOUS ELECTRODES

**0409T**
INSERTION OR REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM, INCLUDING CONTRACTILITY EVALUATION WHEN PERFORMED, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; PULSE GENERATOR ONLY

**0410T**
INSERTION OR REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM, INCLUDING CONTRACTILITY EVALUATION WHEN PERFORMED, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; ATRIAL ELECTRODE ONLY

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
0421T TRANSURETHRAL WATERJET ABLATION OF PROSTATE, INCLUDING CONTROL OF POST-OPERATIVE BLEEDING, INCLUDING ULTRASOUND GUIDANCE, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURERETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED WHEN PERFORMED)
0422T TACTILE BREAST IMAGING BY COMPUTER-AIDED TACTILE SENSORS, UNILATERAL OR BILATERAL
0423T SECRETORY TYPE II PHOSPHOLIPASE A2 (SPLA2-IIA)
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)
0425T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
0426T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
0427T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY
0428T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY
0429T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
0430T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
0431T REMOVAL AND REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA, PULSE GENERATOR ONLY
0432T REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
0433T REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
0434T INTERROGATION DEVICE EVALUATION IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA
0435T PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; SINGLE SESSION
0436T PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; DURING SLEEP STUDY
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)
0440T ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; UPPER EXTREMITY DISTAL/PERIPHERAL NERVE
0441T ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; LOWER EXTREMITY DISTAL/PERIPHERAL NERVE

ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; NERVE PLEXUS OR OTHER TRUNCAL NERVE (EG, BRACHIAL PLEXUS, PUDENDAL NERVE)

REAL-TIME SPECTRAL ANALYSIS OF PROSTATE TISSUE BY FLUORESCENCE SPECTROSCOPY, INCLUDING IMAGING GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

INITIAL PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING FITTING, TRAINING, AND INSERTION, UNILATERAL OR BILATERAL

SUBSEQUENT PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING RE-TRAINING, AND REMOVAL OF EXISTING INSERT, UNILATERAL OR BILATERAL

CREATION OF SUBCUTANEOUS POCKET WITH INSERTION OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR, INCLUDING SYSTEM ACTIVATION AND PATIENT TRAINING

REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR FROM SUBCUTANEOUS POCKET VIA INCISION

REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR WITH CREATION OF SUBCUTANEOUS POCKET AT DIFFERENT ANATOMIC SITE AND INSERTION OF NEW IMPLANTABLE SENSOR, INCLUDING SYSTEM ACTIVATION

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)

INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; COMPLETE SYSTEM (COUNTERPULSATION DEVICE, VASCULAR GRAFT, IMPLANTABLE VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND SUBCUTANEOUS ELECTRODES)

INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; MECHANO-ELECTRICAL SKIN INTERFACE

INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; SUBCUTANEOUS ELECTRODE

REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; COMPLETE SYSTEM (AORTIC COUNTERPULSATION DEVICE, VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES)

REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; MECHANO-ELECTRICAL SKIN INTERFACE

REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; SUBCUTANEOUS ELECTRODE

RELOCATION OF SKIN POCKET WITH REPLACEMENT OF IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES

REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; SUBCUTANEOUS ELECTRODE

REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE

PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE MECHANO-ELECTRICAL SKIN INTERFACE AND/OR EXTERNAL DRIVER TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, INCLUDING REVIEW AND REPORT, IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, PER DAY INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER, IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, PER DAY

VISUAL EVOKED POTENTIAL, TESTING FOR GLAUCOMA, WITH INTERPRETATION AND REPORT

SUPRACHOROIDAL INJECTION OF A PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)

INSERTION OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO PULSE GENERATOR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

REVISION OR REPLACEMENT OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR

REMOVAL OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY
### Group 2 Paragraph:
**Group 2 - Components of Another Service, Never Separately Billable to the Contractor or the Patient**

- Allergy - AG prep
- Anesthesia IV start or intubation
- Angiojet thrombectomy any artery or vein
- Application of mitomycin
- Cast mold
- Cormatrix
- Coronary sinus venography
- Embolic protection device
- Eye retractor advancement
- Gliasite balloon placement
- Implantation/placement of antibiotic beads
- Implantation of Doppler device
- Intraoperative blood flow measurement
- On Q pain pump placement and/or management
- Pentacam
- PICC removal (when billed by same provider)
- Pin fixation
- Pope earwick
- Potential acuity meter
- Preferential hyperacuity perimeter
- Pump catheter placement
- Pupillography or measure of alertness by pupillometry
- Resection/ligation of atrial appendage
- Schirmer test (ophthalmic mucous membrane test)
- Stat fee
- Stryker pain pump insertion
- Suture removal (when billed by same provider)
- Symphony system for procedure
- Two week home auto CPAP titration study
- Ultrasound guidance for fiducial marker placement
- Via modem transmission telemedicine
- Visiometer testing

### Group 2 Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93050</td>
<td>ARTERIAL PRESSURE WAVEFORM ANALYSIS FOR ASSESSMENT OF CENTRAL ARTERIAL PRESSURES, INCLUDES OBTAINING WAVEFORM(S), DIGITIZATION AND APPLICATION OF NONLINEAR MATHEMATICAL TRANSFORMATIONS TO DETERMINE CENTRAL ARTERIAL PRESSURES AND AUGMENTATION INDEX, WITH INTERPRETATION AND REPORT, UPPER EXTREMITY ARTERY, NON-INVASIVE</td>
</tr>
<tr>
<td>0126T</td>
<td>COMMON CAROTID INTIMA-MEDIA THICKNESS (IMT) STUDY FOR EVALUATION OF ATHEROSCLEROTIC BURDEN OR CORONARY HEART DISEASE RISK FACTOR ASSESSMENT</td>
</tr>
<tr>
<td>0159T</td>
<td>COMPUTER-AIDED DETECTION, INCLUDING COMPUTER ALGORITHM ANALYSIS OF MRI IMAGE DATA FOR LESION DETECTION/CHARACTERIZATION, PHARMACOKINETIC ANALYSIS, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, BREAST MRI (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>0174T</td>
<td>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)</td>
</tr>
<tr>
<td>0175T</td>
<td>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</td>
</tr>
<tr>
<td>0208T</td>
<td>PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED; AIR ONLY</td>
</tr>
<tr>
<td>0209T</td>
<td>PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED; AIR AND BONE</td>
</tr>
<tr>
<td>0210T</td>
<td>SPEECH AUDIOMETRY THRESHOLD, AUTOMATED;</td>
</tr>
<tr>
<td>0211T</td>
<td>SPEECH AUDIOMETRY THRESHOLD, AUTOMATED; WITH SPEECH RECOGNITION</td>
</tr>
<tr>
<td>0212T</td>
<td>COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (0209T, 0211T COMBINED), AUTOMATED</td>
</tr>
</tbody>
</table>
0399T MYOCARDIAL STRAIN IMAGING (QUANTITATIVE ASSESSMENT OF MYOCARDIAL MECHANICS USING IMAGE-BASED ANALYSIS OF LOCAL MYOCARDIAL DYNAMICS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)  
IMPLANTATION OF NON-BIOLOGIC OR SYNTHETIC IMPLANT (EG, POLYPROPYLENE) FOR FASCIAL REINFORCEMENT OF THE ABDOMINAL WALL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Group 3 Paragraph:  
Group 3 – Statutorily Non-covered Service, the Patient is Liable for Payment

- Astigmatic keratotomy
- CO2 laser resurfacing of lip
- INTIMA-MEDIA Thickness (IMT) Scan
- Occlusal orthotic appliance
- Orthomolecular medicine
- Validated, statistically reliable, randomized, controlled, single-patient clinical investigation of FDA approved chronic care drugs, provided by a pharmacist, interpretation and report to the prescribing health care professional

Group 3 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
General Information

Associated Information
The medical record must be made available to Medicare upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits in addition to guidance in this LCD. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare. Whichever guidance is more restrictive should be adhered to.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

The Section titled "Does the 'CPT 30% Rule' apply?" needs clarification. This rule comes from the AMA (American Medical Association), the organization that holds the copyrights for all CPT codes. The rule states that if, in a given section (e.g., surgery) or subsection (e.g., surgery, integumentary) of the CPT Manual, more than 30% of the codes are listed in the LCD, then the short descriptors must be used rather than the long descriptors found in the CPT Manual.

This policy is subject to the reasonable and necessary guidelines and the limitation of liability provision.

This medical policy consolidates and replaces all previous policies and publications on this subject by Noridian and its predecessors for Medicare Part B.

This final LCD, effective 05/31/2016 combines JEA L36217 into the JEB LCD so that both JEA and JEB contract numbers will have the same final MCD LCD number.

Sources of Information
CMS Manual System Transmittal 1315; Change Request 5667, August 10, 2007

Policies from other states:
First Coast Services Option policy
TrailBlazer Health Enterprises, LLC policy
Noridian Carrier Advisory Committee Members


<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation</th>
<th>Reason(s) for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2018</td>
<td>R20</td>
<td>Effective 01/01/2018, this LCD is revised to remove Category III CPT code 0449T from Group I.</td>
<td></td>
</tr>
<tr>
<td>01/01/2018</td>
<td>R19</td>
<td>At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore, not all the fields included in the LCD are applicable as noted in this policy. LCD revised for the 2018 HCPCS/CPT updates. Effective 12/31/2017 the following codes will be deleted from Group 1: 0255T, 0293T, 0294T, 0299T, 0300T, 0301T, 0302T, 0303T, 0304T, 0305T, 0306T, 0310T, 0340T, 0438T, 34806, 93982.</td>
<td></td>
</tr>
<tr>
<td>10/27/2017</td>
<td>R18</td>
<td>Effective 10/27/2017, this LCD is being revised for the removal of CPT 43210 from Group 1.</td>
<td></td>
</tr>
<tr>
<td>01/18/2017</td>
<td>R17</td>
<td>7/26/17 - Category III CPT code 0275T will be removed from the Non-Covered Services LCD due to the Coverage with Evidence Development (CED) clinical trial guidelines found in National Coverage Determination (NCD) 150.13, effective 12/6/16.</td>
<td></td>
</tr>
<tr>
<td>01/18/2017</td>
<td>R16</td>
<td>04/18/2017 - Removal of Leadless Pacemaker Category III CPT codes 0387T - 0391T from Group I effective 1/18/2017.</td>
<td></td>
</tr>
<tr>
<td>01/01/2017</td>
<td>R15</td>
<td>Effective 01/01/2017 the description Decision DX UM is removed from Group I description of miscellaneous procedure list. LCD revised for the 2017 HCPCS/CPT codes: Added to Group I 43284, 43285, 0446T, 0447T, 0448T, 0449T, 0450T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0464T, 0465T, 0466T, 0467T, 0468T.</td>
<td></td>
</tr>
<tr>
<td>01/01/2017</td>
<td>R14</td>
<td>Effective 12/31/2016 the following codes have been deleted: 0019T, 0169T, 0286T, 0287T, 0288T, 0289T, 0291T, 0292T, 0392T (replaced with 43284), 0393T (replaced with 43285).</td>
<td></td>
</tr>
<tr>
<td>08/08/2016</td>
<td>R13</td>
<td>The LCD is revised to remove 86352 from group 1, effective August 8, 2016.</td>
<td></td>
</tr>
<tr>
<td>Revision Date</td>
<td>Revision History Number</td>
<td>Revision History Explanation</td>
<td>Reason(s) for Change</td>
</tr>
<tr>
<td>---------------</td>
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<td>-----------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>07/01/2016</td>
<td>R12</td>
<td>The LCD is revised to add the following Category III CPT codes effective 7/1/2016: 0437T, 0438T, 0440T, 0441T, 0442T, 0439T, 0443T, 0444T, 0445T.</td>
<td>Reconsideration Request</td>
</tr>
<tr>
<td>05/31/2016</td>
<td>R11</td>
<td>Transcranial stimulation for depression listed under Group I for unlisted procedures code descriptions should have been removed when this LCD was revised to remove CPT codes 90867, 90868 and 90869 from Group 1. The effective date of 4/1/2016 remains the same.</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
<tr>
<td>05/31/2016</td>
<td>R10</td>
<td>This policy is revised effective 05/31/2016 only to combine JEA L36217 into the JEB LCD so that both JEA and JEB contract numbers will have the same final MCD LCD number.</td>
<td>Typographical Error</td>
</tr>
<tr>
<td>05/31/2016</td>
<td>R9</td>
<td>This LCD is revised to remove CPT codes 82172 and 83698 from group 1 effective 5/31/2016. Also a correction is made for CPT code 0281T removed from LCD with an effective date of 2/8/2016. The correct effective date should be 2/07/2016 and not 2/8/2016.</td>
<td>Other (This policy is revised effective 05/31/2016 only to combine JEA L36217 into the JEB LCD so that both JEA and JEB contract numbers will have the same final MCD LCD number.)</td>
</tr>
<tr>
<td>04/01/2016</td>
<td>R8</td>
<td>This LCD is revised to remove CPT codes 90867, 90868 and 90869 from Group 1 with an effective date of 4/1/2016.</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
<tr>
<td>02/08/2016</td>
<td>R7</td>
<td>The LCD is revised to remove CPT Code 0281T from Group 1 with an effective date of 2/8/2016.</td>
<td>Typographical Error</td>
</tr>
<tr>
<td>01/11/2016</td>
<td>R6</td>
<td>The LCD is revised to remove 22856, 22858 and 22861 effective 1/1/2016. The LCD is revised to add the following CPT Codes in Group 1: 43210, 0396T, 0397T, 0398T, 0400T, 0401T, 0402T, 0406T, 0407T, 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0419T, 0420T, 0421T, 0422T, 0423T, 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T. Group 2 – 93050, 0399T</td>
<td>Creation of Uniform LCDs Within a MAC Jurisdiction</td>
</tr>
<tr>
<td>01/01/2016</td>
<td>R5</td>
<td>Group 3 - 0403T, 0405T. Effective date is 1/1/2016. Transoral Incisionless Fundoplication is removed from the miscellaneous procedure list. The procedure code is 43210 for 2016 and is added to group 1. 93050 added in group 2 to replace 0311T deleted 1/1/2016.</td>
<td>Reconsideration Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following CPT codes removed from this LCD because they were deleted effective 1/1/2016:</td>
<td>Reconsideration Request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Revision History Explanation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>12/01/2015</td>
<td>R4</td>
<td>Medialization Thyroplasty is removed from the policy listed in Group 1 of unlisted procedure code list and should be billed with CPT code 31588 effective December 1, 2015.</td>
<td>Other (LCD revised to be consistent within a MAC Jurisdiction.)</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>R3</td>
<td>The LCD revised to add 0392T and 0393T to Group 1 and to remove CPT code 91112 from group 1.</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>R2</td>
<td>The CPT Code 0262T was removed from Group 1. Each claim for CPT Code 0262T will be reviewed on a case-by-case basis.</td>
<td>Reconsideration Request</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>R1</td>
<td>The CPT Code 0262T was removed from Group 1 because the same code was also removed from the ICD9 LCD copy effective 7/9/2015.</td>
<td>Reconsideration Request</td>
</tr>
</tbody>
</table>
Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) A55607 - Additional Information Required for Coverage and Pricing for Category III CPT® Codes

Related National Coverage Documents N/A

Public Version(s) Updated on 02/01/2018 with effective dates 01/01/2018 - N/A Updated on 12/01/2017 with effective dates 01/01/2018 - N/A Updated on 10/26/2017 with effective dates 10/27/2017 - 12/31/2017 Updated on 08/23/2017 with effective dates 01/18/2017 - 10/26/2017 Updated on 04/18/2017 with effective dates 01/18/2017 - N/A Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

- Non Covered Services
- Cosmetic
- Not proven effective
- Investigational
- Experimental
- Not medically necessary
- Statutorily Non-covered

Read the LCD Disclaimer Back to Top