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

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

LCD Information

Document Information

LCD ID **Original Effective Date**

L36219

LCD Title
Non-Covered Services

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 01/01/2019

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

CMS National Coverage Policy

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only

those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 23, Section 30 A

Medicare Program Integrity Manual

Medicare National Coverage Determination Manual
230.14 - Ultrafiltration Monitor

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Medicare does not cover items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Section 1862 (a) (1) of the Social Security Act is the basis for denying payment for types of care, or specific items, services, or procedures that are not excluded by any other statutory clause and meet all technical requirements for coverage but 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 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 <u>for a specific indication</u> 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 <u>www.noridianmedicare.com</u> 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

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 to all claims.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
014x	Hospital - Laboratory Services Provided to Non-patients
018x	Hospital - Swing Beds
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
028x	Skilled Nursing - Swing Beds
072x	Clinic - Hospital Based or Independent Renal Dialysis Center
074x	Clinic - Outpatient Rehabilitation Facility (ORF)
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)

CODE	DESCRIPTION
085x	Critical Access Hospital

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.

CODE	DESCRIPTION
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

CODE	DESCRIPTION
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
0740	EEG (Electroencephalogram) - General Classification
0750	Gastro-Intestinal (GI) Services - General Classification
076X	Specialty Services - General Classification
0790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - General Classification
0900	Behavioral Health Treatment/Services - General Classification
092X	Other Diagnostic Services - General Classification
094X	Other Therapeutic Services - 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 probablilty 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 & hydrobed modality)
- 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
• Suprachoroidial delivery of pharmacologic agent
• Therabite appliance dispensed due to trismus
• Therapy using Superluminous Diodes
• Transmyocardial transcatheter closure of ventricular spetal 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 AgAdditional 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:

CODE	DESCRIPTION
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])
43257	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF LOWER ESOPHAGEAL SPHINCTER AND/OR GASTRIC CARDIA, FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
43284	LAPAROSCOPY, SURGICAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND), INCLUDING CRUROPLASTY WHEN PERFORMED
43285	REMOVAL OF ESOPHAGEAL SPHINCTER AUGMENTATION DEVICE
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])

CODE	DESCRIPTION
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
62287	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
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 HYSTERESIS 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
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
0054T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0055T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC

CODE	DESCRIPTION
	PROCEDURE, WITH IMAGE-GUIDANCE 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
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)
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
0163T	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

CODE	DESCRIPTION
	DISC), ANTERIOR APPROACH, EACH ADDITIONAL INTERSPACE, LUMBAR (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
0205T	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)
0206T	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)
0232T	INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED
0234T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; RENAL ARTERY
0235T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; VISCERAL ARTERY (EXCEPT RENAL), EACH VESSEL

CODE	DESCRIPTION
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
0253T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE
0263T	INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; COMPLETE PROCEDURE INCLUDING UNILATERAL OR BILATERAL BONE MARROW HARVEST
0264T	INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; COMPLETE PROCEDURE EXCLUDING BONE MARROW HARVEST
0265T	INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; UNILATERAL OR BILATERAL BONE MARROW HARVEST ONLY FOR INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY
0266T	IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; TOTAL SYSTEM (INCLUDES GENERATOR PLACEMENT, UNILATERAL OR BILATERAL LEAD PLACEMENT, INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)
0267T	IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; LEAD ONLY, UNILATERAL (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)
0268T	IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; PULSE GENERATOR ONLY (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)
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,

CODE	DESCRIPTION
	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 (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 ESOPHAGOGASTRIC JUNCTION (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

CODE	DESCRIPTION
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
0341T	QUANTITATIVE PUPILLOMETRY WITH INTERPRETATION AND REPORT, UNILATERAL OR 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
0355T	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), COLON, WITH INTERPRETATION AND REPORT

CODE	DESCRIPTION
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
0362T	BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT, REQUIRING THE FOLLOWING COMPONENTS: ADMINISTRATION BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHO IS ON SITE; WITH THE ASSISTANCE OF TWO OR MORE TECHNICIANS; FOR A PATIENT WHO EXHIBITS DESTRUCTIVE BEHAVIOR; COMPLETION IN AN ENVIRONMENT THAT IS CUSTOMIZED TO THE PATIENT'S BEHAVIOR.
0373T	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT, REQUIRING THE FOLLOWING COMPONENTS: ADMINISTRATION BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WHO IS ON SITE; WITH THE ASSISTANCE OF TWO OR MORE TECHNICIANS; FOR A PATIENT WHO EXHIBITS DESTRUCTIVE BEHAVIOR; COMPLETION IN AN ENVIRONMENT THAT IS CUSTOMIZED TO THE PATIENT'S BEHAVIOR.
0375T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), CERVICAL, THREE OR MORE LEVELS
0376T	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
0382T	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, REVIEW AND INTERPRETATION ONLY
0383T	EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING FROM 15 TO 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION

CODE	DESCRIPTION
	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
0384T	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
0385T	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
0386T	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
CODE	DESCRIPTION
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)
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
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

CODE	DESCRIPTION
	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
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

CODE	DESCRIPTION
	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;

CODE	DESCRIPTION
	LOWER EXTREMITY DISTAL/PERIPHERAL NERVE
0442T	ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; NERVE PLEXUS OR OTHER TRUNCAL NERVE (EG, BRACHIAL PLEXUS, PUDENDAL NERVE)
0443T	REAL-TIME SPECTRAL ANALYSIS OF PROSTATE TISSUE BY FLUORESCENCE SPECTROSCOPY, INCLUDING IMAGING GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
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
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
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)
0451T	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)
0452T	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
0453T	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
0454T	INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC

CODE	DESCRIPTION
	COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; SUBCUTANEOUS ELECTRODE
0455T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; COMPLETE SYSTEM (AORTIC COUNTERPULSATION DEVICE, VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES)
0456T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL
0457T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; MECHANO-ELECTRICAL SKIN INTERFACE
0458T	REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; SUBCUTANEOUS ELECTRODE
0459T	RELOCATION OF SKIN POCKET WITH REPLACEMENT OF IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES
0460T	REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; SUBCUTANEOUS ELECTRODE
0461T	REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; AORTIC COUNTERPULSATION DEVICE
0462T	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
0463T	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
0464T	VISUAL EVOKED POTENTIAL, TESTING FOR GLAUCOMA, WITH INTERPRETATION AND REPORT
0465T	SUPRACHOROIDAL INJECTION OF A PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)
0466T	INSERTION OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO PULSE GENERATOR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0467T	REVISION OR REPLACEMENT OF CHEST WALL RESPIRATORY SENSOR ELECTRODE

CODE	DESCRIPTION
	OR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR
0468T	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
- Intrapericardial defibrillator coil
- 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:

CODE	DESCRIPTION
93050	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

CODE	DESCRIPTION
	INTERPRETATION AND REPORT, UPPER EXTREMITY ARTERY, NON-INVASIVE
0126T	COMMON CAROTID INTIMA-MEDIA THICKNESS (IMT) STUDY FOR EVALUATION OF ATHEROSCLEROTIC BURDEN OR CORONARY HEART DISEASE RISK FACTOR ASSESSMENT
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)
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
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
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)
0437T	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:

CODE	DESCRIPTION
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
99605	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, NEW PATIENT
99606	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, ESTABLISHED PATIENT
99607	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)
0378T	VISUAL FIELD ASSESSMENT, WITH CONCURRENT REAL TIME DATA ANALYSIS AND ACCESSIBLE DATA STORAGE WITH PATIENT INITIATED DATA TRANSMITTED TO A REMOTE SURVEILLANCE CENTER FOR UP TO 30 DAYS; REVIEW AND INTERPRETATION WITH REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
0379T	VISUAL FIELD ASSESSMENT, WITH CONCURRENT REAL TIME DATA ANALYSIS AND ACCESSIBLE DATA STORAGE WITH PATIENT INITIATED DATA TRANSMITTED TO A REMOTE SURVEILLANCE CENTER FOR UP TO 30 DAYS; TECHNICAL SUPPORT AND PATIENT INSTRUCTIONS, SURVEILLANCE, ANALYSIS, AND TRANSMISSION OF DAILY AND EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
0380T	COMPUTER-AIDED ANIMATION AND ANALYSIS OF TIME SERIES RETINAL IMAGES FOR THE MONITORING OF DISEASE PROGRESSION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
0403T	PREVENTIVE BEHAVIOR CHANGE, INTENSIVE PROGRAM OF PREVENTION OF DIABETES USING A STANDARDIZED DIABETES PREVENTION PROGRAM CURRICULUM, PROVIDED TO INDIVIDUALS IN A GROUP SETTING, MINIMUM 60 MINUTES, PER DAY
0405T	OVERSIGHT OF THE CARE OF AN EXTRACORPOREAL LIVER ASSIST SYSTEM PATIENT REQUIRING REVIEW OF STATUS, REVIEW OF LABORATORIES AND OTHER STUDIES, AND REVISION OF ORDERS AND LIVER ASSIST CARE PLAN (AS APPROPRIATE), WITHIN A CALENDAR MONTH, 30 MINUTES OR MORE OF NON-FACE-TO-FACE TIME

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

XXX00 Not Applicable

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
XX000	Not Applicable

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Additional ICD-10 Information

N/A

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

Current Procedural Terminology (CPT®), Professional Edition American Medical Association

1. Basu, Sanghamitra,: Mild Procedure: Single-site prospective IRB study. *Clin J Pain;* 2012;28(3):254-258.

2. Boyan, Barbara D.,Schwartz, Zvi, Patterson, Thomas E., Muschler, George: Clinical use of platelet-rich plasma in orthopaedics. *American Academy of Orthopaedic Surgeons Now* 2007; 1(7).

3. Brodke D, Pedrozo HA, Kapur TA, et al: Bone grafts prepared with selective cell retention technology heal canine segmental defects as effectively as autograft. *J Orthop Res* 2006;24:857-866.

4. Brown, Lora L: A double-blind, randomized, prospective study of epidural steroid injection vs the mild procedure in patients with symptomatic lumbar spinal stenosis. *Pain Practice;* 2012;12(5):333-341.

5. Chopko, Bohdan W.: Regarding failure of percutaneous remodeling of the ligamentum flavum and lamina for neurogenic claudication. Neurosurgery, 2012;71:E525-E526.

6. Chopko, Bohdan, and Caraway, David J.: MiDAS I (mild decompression alternative to open surgery): A preliminary report of a prospective, multi-center clinical study. *Pain Physician* 2010;13:369-378.

7. Deer, Timothy R., Mekhail, Nagy, Lopez,Gabriel, & Amirdelfan, Kasra: The evolving treatment of pain. Minimally invasive lumbar decompression for spinal stenosis. *www.neurosurgicalreview.com, Southern Academic Press, JNR* 2011,1(S1):29-32.

8. Deer, Timothy R. and Kapural, Leonardo: New image-guided ultra minimally invasive lumbar decompression method: The mild procedure. *www.painphysicianjournal.com, Pain Physician* 2010;13(1):35-41.

9. Fourney, Daryl R.: In Reply, ,i>Neurosurgery, 2012;71:E526-E528.

10. Gruber R, Kandler B, Fischer MB, Watzek G: Osteogenic differentiation induced by bone morphogenetic proteins can be suppressed by platelet-released supernatant in vitro. *Clin Oral Implants Res* 2006;17:188-193.

11. Kark LR, Karp JM, Davies JE: Platelet releasate increases the proliferation and migration of bone marrow-derived cells cultured under osteogenic conditions. *Clin Oral Implants Res* 2006;17:321-327.

12. Li H, Zou X, Xue Q, Egund N, Lind M, Bunger C: Anterior lumbar interbody fusion with carbon fiber cage loaded with bioceramics and platelet-rich plasma: An experimental study on pigs. *Eur Spine J* 2004;13:354-358.

13. Lingreen, Richard and Grider, Jay S.: Retrospective review of patient self-reported improvement and post-procedure findings for mild (Minimally Invasive Lumbar Decompression). *www.painphysicianjournal.com, Pain Physician* 2010;13:555-560.

14. Mekhail, Nagy, Vallejo, Ricardo, Coleman, Mark H., Benyamin, Ramsin M.: Long-term results of percutaneous lumbar decompression mild for spinal stenosis. *Pain Practice* 2012;12(3):184-93.

15. Murray MM, Spindler KP, Ballard P, Welch TP, Zurakowski D, Nanney LB: Enhanced histologic repair in a central

wound in the anterior cruciate ligament with a collagen-platelet-rich plasma scaffold. J Orthop Res 2007;25:1007-1017.

16. Muschler GF, Matsukura Y, Nitto H, et al: Selective retention of bone marrow-derived cells to enhance spinal fusion. *Clin Orthop Relat Res* 2005;(432):242-251.

17. Muschler GF, Nitto H, Matsukura Y, et al: Spine fusion using cell matrix composites enriched in bone marrow-derived cells. *Clin Orthop Relat Res* 2003;(407):102-118.

18. Rai B, Oest ME, Dupont KM, Ho KH, Teoh SH, Guldberg RE: Combination of platelet-rich plasma with polycaprolactone-tricalcium phosphate scaffolds for segmental bone defect repair. J *Biomed Mater Res A* 2007;81:888-899.

19. Ranly DM, McMillan J, Krause WF, Lohmann CH, Boyan BD, Schwartz Z: Platelet-rich plasma: A review of its components and use in bone repair, in Akay M (ed): *Encyclopedia of Biomedical Engineering,* vol 5. Hoboken, NJ: John Wiley & Sons, Inc., 2006, pp 2804-2815.

20. Ranly DM, Lohmann CH, Andreacchio D, Boyan BD, Schwartz Z.: Platelet-rich plasma inhibits demineralized bone matrix-induced bone formation in nude mice. *J Bone Joint Surg Am* 2007;89:139-147.

21. Schomer, D.F., Solsberg, D. Wong, W, Chopko, B.W.: MILD lumbar decompression for the treatment of lumbar spinal stenosis. *The Neuroradiology Journal* 2011;24:620-626.

22. Schwartz Z, Somers A, Mellonig JT, et al: Ability of commercial demineralized bone allograft to induce bone formation is donor age-dependent but not gender-dependent (abstract). *Trans Orthopaed Res Soc* 1997;22:230.

23. Sipe JB, Zhang J, Waits C, Skikne B, Garimella R, Anderson HC: Localization of bone morphogenetic proteins (BMPs)-2, -4, and -6 within megakaryocytes and platelets. *Bone* 2004;35:1316-1322.

24. Thibault L, Beausejour A, de Grandmont MJ, Lemieux R, Leblanc JF: Characterization of blood components prepared from whole-blood donations after a 24-hour hold with the platelet-rich plasma method. *Transfusion* 2006;46:1292-1299.

25. Tumialian, Luis M., Marciano, Frederick F., Theodore, Nicholas:
Letters to the Editor. Regarding: Long-term results of percutaneous lumbar decompression mild for spinal stenosis. *Pain Practice,* 2012;12(3):252.

26. Weibrich G, Kleis WK, Hitzler WE, Hafner G.: Comparison of the platelet concentrate collection system with the plasma-rich-in-growth-factors kit to produce platelet-rich plasma: A technical report. *Int J Oral Maxillofac Implants* 2005;20:118-123.

27. Weiner BK, Walker M: Efficacy of autologous growth factors in lumbar intertransverse fusions. *Spine* 2003;28:1968-1970.

28. Wilkinson, Jeffrey S.; Fourney, Daryl R.: Failure of percutaneous remodeling of the ligamentum flavum and lamina for neurogenic claudication. *Neurosurgery;* 2012 71(1):86-92.

29. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults. Circulation 2013. Accessed online at *https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf April 9, 2015.*

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
01/01/2019	R26	Effective 1/1/2019, this LCD is being revised to remove Category III CPT code 0402T from Grou 1/8/19 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict cov comment and notice. This revision is not a restriction to the coverage determination and therefo included in the LCD are applicable as noted in this policy.
01/01/2019	R25	The LCD revised to remove deleted CPT codes effective 1/1/2019. • Deleted CPT from Group 1: ▫ 0190T, 0195T, 0196T, 0337T, 0346T, 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0369T, 0370T, 0371T, 0372T, 0374T, 0406T, 0407T and ▫ 0159T from group 2. • Description changed for the following codes: ▫ 0335T – Insertion of sinus tarsi implant ▫ 0362T – Behavior identification supporting assessment, each 15 minutes of technici with a patient, requiring the following components: administration by the physician care professional who is on site; with the assistance of two or more technicians; for destructive behavior; completion in an environment that is customized to the patien ▫ 0373T – Adaptive behavior treatment with protocol modification, each 15 minutes o to-face with a patient, requiring the following components: administration by the ph health care professional who is on site; with the assistance of two or more technicia exhibits destructive behavior; completion in an environment that is customized to th At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore, not all LCD are applicable as noted in this policy.
08/24/2018	R24	Effective 8/24/2018, this LCD is revised to remove CPT 32998 from Group 1. At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore, not all LCD are applicable as noted in this policy.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
06/21/2018	R23	Effective 6/21/2018, this LCD is being revised to remove Category III CPT code 0254T from Gro At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore not all t LCD are applicable as noted in this policy.
05/24/2018	R22	Effective 5/24/2018, this LCD is being revised to remove Category III CPT code 0398T from Gro At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore not all t LCD are applicable as noted in this policy.
04/06/2018	R21	Effective 4/6/2018, the LCD is being revised to remove CPT code 84145 from Group I. 4/25/2018 - At this time, 21st Century Cures Act will apply to new and revised LCDs that restric requires comment and notice. This revision is not a restriction to the coverage determination an fields included in the LCD are applicable as noted in this policy.
01/01/2018	R20	Effective 01/01/2018, this LCD is revised to remove Category III CPT code 0449T from Group I. At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore, not all LCD are applicable as noted in this policy.
01/01/2018	R19	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, 034 The code description was changed for CPT code 32998 from Group 1 At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage w and notice. This revision is not a restriction to the coverage determination and therefore not all t LCD are applicable as noted in this policy.
10/27/2017	R18	Effective 10/27/2017, this LCD is being revised for the removal of CPT 43210 from Group 1.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		10/17/17 - At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict comment and notice. This revision is not a restriction to the coverage determination and therefo included in the LCD are applicable as noted in this policy.
01/18/2017	R17	7/26/17 - Category III CPT code 0275T will be removed from the Non-Covered Services LCD du Evidence Development (CED) clinical trial guidelines found in National Coverage Determination (12/6/16. 7/26/17 - At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict c comment and notice. This revision is not a restriction to the coverage determination and therefo included in the LCD are applicable as noted in this policy.
01/18/2017	R16	04/18/2017 - Removal of Leadless Pacemaker Category III CPT codes 0387T - 0391T from Grou
01/01/2017	R15	Effective 01/01/2017 the description Decision DX UM is removed from Group I description of mis list.
01/01/2017	R14	LCD revised for the 2017 HCPCS/CPT codes: Added to Group I 43284, 43285, 0446T, 0447T, 0448T, 0449T, 0450T, 0451T, 0452T, 0453T, 0 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0464T, 0465T, 0466T, 0467T, 0468T. Effective 12/31/2016 the following codes have been deleted:0019T, 0169T, 0286T, 0287T, 0288 0292T, 0392T (replaced with 43284), 0393T (replaced with 43285).
08/08/2016	R13	The LCD is revised to remove 86352 from group 1, effective August 8, 2016.
07/01/2016	R12	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.
05/31/2016	R11	Transcranial stimulation for depression listed under Group I for unlisted procedures code descrip removed when this LCD was revised to remove CPT codes 90867, 90868 and 90869 from Group 4/1/2016 remains the same.
05/31/2016	R10	This policy is revised effective 05/31/2016 only to combine JEA L36217 into the JEB LCD so that contract numbers will have the same final MCD LCD number.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
05/31/2016	R9	This LCD is revised to remove CPT codes 82172 and 83698 from group 1 effective 5/31/2016. A for CPT code 0281T removed from LCD with an effective date of 2/8/2016. The correct effective 2/07/2016 and not 2/8/2016.
04/01/2016	R8	This LCD is revised to remove CPT codes 90867, 90868 and 90869 from Group 1 with an effecti
02/08/2016	R7	The LCD is revised to remove CPT Code 0281T from Group 1 with an effective date of 2/8/2016.
01/11/2016	R6	The LCD is revised to remove 22856, 22858 and 22861 effective 1/11/2016.
01/01/2016	R5	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, 041 0414T, 0415T, 0416T, 0417T, 0418T, 0419T, 0420T, 0421T, 0422T, 0423T, 0424T, 0425T, 042 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T. Group 2 – 93050, 0399T Group 3 - 0403T, 0405T. Effective date is 1/1/2016. Transoral Incisionless Fundoplication is removed from the miscellaneous procedure list. The proc 2016 and is added to group 1.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		93050 added in group 2 to replace 0311T deleted 1/1/2016. The following CPT codes removed from this LCD because they were deleted effective 1/1/2016: 0103T, 0123T, 0223T, 0224T, 0225T, 0233T, 0240T, 0241T, 0243T, 0244T and 0311T.
12/01/2015	R4	Medialization Thyroplasty is removed from the policy listed in Group 1 of unlisted procedure cod and should be billed with CPT code 31588 effective December 1, 2015.
10/01/2015	R3	The LCD revised to add 0392T and 0393T to Group 1 and to remove CPT code 91112 from grou
10/01/2015	R2	The CPT Code 0262T was removed from Group 1. Each claim for CPT Code 0262T will be reviewe basis.
10/01/2015	R1	The CPT Code 0262T was removed from Group 1 because the same code was also removed fron effective 7/9/2015.

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 01/10/2019 with effective dates 01/01/2019 - N/A
Updated on 12/04/2018 with effective dates 01/01/2019 - N/A
Updated on 08/07/2018 with effective dates 08/24/2018 - 12/31/2018
Updated on 06/05/2018 with effective dates 06/21/2018 - 08/23/2018
Updated on 05/10/2018 with effective dates 05/24/2018 - 06/20/2018
Updated on 04/27/2018 with effective dates 04/06/2018 - 05/23/2018
Updated on 02/01/2018 with effective dates 01/01/2018 - 04/05/2018
Updated on 12/01/2017 with effective dates 01/01/2018 - 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