

Category III CPT Codes

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[➔ Instructions for Use](#)

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| Related Policies |
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| <ul style="list-style-type: none"> Refer to the Coverage Rationale |

Coverage Rationale

Overview

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

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

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

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

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

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

This UnitedHealthcare Medicare Advantage Medical Policy is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Medical Policies that include category III codes.

For coverage guidelines for items and services **not** listed in this policy, first search the [Medicare Coverage Database](#) to confirm no applicable Medicare coverage guidelines exist. After searching the [Medicare Coverage Database](#), if no National Coverage Determinations (NCD)/Local Coverage Determinations (LCD)/Local Coverage Articles (LCA) are

found, then search for a UnitedHealthcare Medicare Advantage Medical Policy that specifically addresses the service/code. If none is found, refer to the table below.

Note: The guidelines in this Medical Policy are for specific services only. For services not addressed in this Medical Policy, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations, and Local Coverage Articles).

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|--|---|--|--|
| 0054T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure) | Refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Orthopedic Procedures, Devices, and Products . | | |
| 0055T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure) | Refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Orthopedic Procedures, Devices, and Products . | | |
| 0071T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Uterine Services and Procedures . | | |
| 0072T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Uterine Services and Procedures . | | |
| 0100T | Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy | No | CGS (A54327) | For coverage guidelines for states/territories with no LCDs/LCAs , refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes . |
| 0101T | Extracorporeal shock wave involving musculoskeletal system, not otherwise specified | Refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Orthopedic Procedures, Devices, and Products . | | |
| 0102T | Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle | Refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Orthopedic Procedures, Devices, and Products . | | |
| 0106T | Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation | No | First Coast L34859 (A57123) Novitas L35081 (A54095) | For coverage guidelines for states/territories with no LCDs/LCAs , refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|--|---|--|--|
| 0107T | Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation | No | First Coast L34859 (A57123) Novitas L35081 (A54095) | For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0108T | Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia | No | First Coast L34859 (A57123) Novitas L35081 (A54095) | For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0109T | Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia | No | First Coast L34859 (A57123) Novitas L35081 (A54095) | For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0110T | Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation | No | First Coast L34859 (A57123) Novitas L35081 (A54095) | For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0202T | Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression . |
| 0232T | Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed | Refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Orthopedic Procedures, Devices, and Products . | | |
| 0238T | Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Lower Extremity Endovascular Procedures . |
| 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 | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |

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|----------|---|--|---|--|
| 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 | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 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 | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0278T | Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation . |
| 0342T | Therapeutic apheresis with selective HDL delipidation and plasma reinfusion | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Apheresis . |
| 0422T | Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0440T | Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Pain Management . | | |
| 0441T | Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Pain Management . | | |
| 0442T | Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve) | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Pain Management . | | |
| 0464T | Visual evoked potential, testing for glaucoma, with interpretation and report | No | NGS L36831 (A57060) | For coverage guidelines for states/territories with no LCDs/LCAs , refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0483T | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|---------------------------|-------------------------------|---|
| 0484T | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g., thoracotomy, transapical) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0489T | Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0490T | Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0505T | Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Lower Extremity Endovascular Procedures . |
| 0512T | Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds . |
| 0513T | Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds . |
| 0543T | Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|--|---|--|--|
| 0544T | Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0545T | Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0564T | Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations | NCD for Human Tumor Stem Cell Drug Sensitivity Assays (190.7) | Noridian L37628 (A56071) Noridian L37630 (A56073) Palmetto L34554 (A56871) | Refer to NCD |
| 0565T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0566T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0569T | Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0570T | Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0582T | Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0598T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (e.g., lower extremity) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds . |

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|----------|--|---------------------------|-------------------------------|--|
| 0599T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (e.g., upper extremity) (List separately in addition to code for primary procedure) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds . |
| 0619T | Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0627T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment . |
| 0628T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment . |
| 0629T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment . |
| 0630T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment . |
| 0633T | Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0634T | Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0635T | Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|--|-------------------------------|--|
| 0636T | Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0637T | Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0638T | Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s) | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer . |
| 0646T | Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0655T | Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0656T | Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Vertebral Body Tethering for Scoliosis . |
| 0657T | Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Vertebral Body Tethering for Scoliosis . |
| 0672T | Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence | Refer to the UnitedHealthcare Medicare Advantage Medical Policy titled Urinary and Fecal Incontinence: Diagnosis and Treatment . | | |
| 0687T | Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|---------------------------|-------------------------------|--|
| 0688T | Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy . |
| 0693T | Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis . |
| 0704T | Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy . |
| 0705T | Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy . |
| 0706T | Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy . |
| 0714T | Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0717T | Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |
| 0718T | Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|--|-------------------------------|---|
| 0719T | Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression . |
| 0720T | Percutaneous electrical nerve field stimulation, cranial nerves, without implantation | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation . |
| 0736T | Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter | NCD for Colonic Irrigation (100.7) | No | Refer to NCD |
| 0737T | Xenograft implantation into the articular surface | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Surgery of the Knee . |
| 0738T | Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0739T | Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0744T | Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (e.g., polyester, ePTFE, bovine pericardium), when performed | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins . |
| 0778T | Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring . |
| 0779T | Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Gastrointestinal Motility Disorders, Diagnosis and Treatment . |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|--|-------------------------------|---|
| 0783T | Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation . |
| 0795T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0796T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0797T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0798T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|--|-------------------------------|--------------|
| 0799T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0800T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0801T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker components) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0802T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0803T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|---|--|-------------------------------|--|
| 0804T | Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0805T | Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0806T | Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Heart Valve Procedures . |
| 0813T | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery . |
| 0814T | Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Bone Healing Enhancement Products . |
| 0823T | Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0824T | Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |

| CPT Code | Description | CMS NCD Coverage Criteria | CMS LCD/LCA Coverage Criteria | Conclusion |
|----------|--|--|-------------------------------|---|
| 0825T | Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0826T | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber | NCD for Leadless Pacemakers (20.8.4) | No | Refer to NCD |
| 0858T | Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation . |
| 0867T | Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50mL | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions . |
| 0868T | High-resolution gastric electrophysiology mapping with simultaneous patient-symptom profiling, with interpretation and report | No | No | Unproven; refer to the UnitedHealthcare Commercial Medical Policy titled Gastrointestinal Motility Disorders, Diagnosis and Treatment . |

Centers for Medicare and Medicaid Services (CMS) Related Documents

| Medicare Administrative Contractor (MAC) with Corresponding States/Territories | |
|--|--|
| MAC Name (Abbreviation) | States/Territories |
| CGS Administrators, LLC (CGS) | KY, OH |
| First Coast Service Options, Inc. (First Coast) | FL, PR, VI |
| National Government Services, Inc. (NGS) | CT, IL, ME, MA, MN, NH, NY, RI, VT, WI |
| Noridian Healthcare Solutions, LLC (Noridian) | AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY |
| Novitas Solutions, Inc. (Novitas) | AR, CO, DE, LA, MD, MS, NJ, NM, OK, PA, TX, DC |
| Palmetto GBA (Palmetto) | AL, GA, NC, SC, TN, VA, WV |
| Wisconsin Physicians Service Insurance Corporation (WPS)* | IA, IN, KS, MI, MO, NE |
| *Note: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers | |

CMS Benefit Policy Manual

Chapter 16; § 10 General Exclusions from Coverage

CMS Transmittal(s)

[Transmittal 11457, Change Request 12761, Dated 06/15/2022 \[July 2022 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)\]](#)

[Transmittal 11472, Change Request 12773, Dated 06/23/2022 \(July 2022 Update of the Ambulatory Surgical Center \(ASC\) Payment System\)](#)

[Transmittal 12053, Change Request 13210, Dated 05/18/2023 \[July 2023 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)\]](#)

[Transmittal 12122, Change Request 13216, Dated 07/05/2023 \(July 2023 Update of the Ambulatory Surgical Center \[ASC\] Payment System\)](#)

MLN Matters

[Article MM12761, July 2022 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)](#)

[Article MM12773, July 2022 Update of the Ambulatory Surgical Center \(ASC\) Payment System](#)

[Article MM13210, July 2023 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)](#)

[Article MM13216, July 2023 Update of the Ambulatory Surgical Center \(ASC\) Payment System](#)

Others

[Medicare Managed Care Manual IOM Pub. No. 100-16, Ch. 4, §90.5](#)

[Physician Fee Schedule Relative Value Files](#)

[Social Security Act \(Title XVIII\), Section 1862\(a\)\(1\)\(A\) Medically Reasonable & Necessary](#)

L35490 Category III Codes

A56902 Billing and Coding: Category III Codes

Policy History/Revision Information

| Date | Summary of Changes |
|------------|---|
| 09/01/2024 | Coverage Rationale <ul style="list-style-type: none">Updated reference link to reflect the current policy type for:<ul style="list-style-type: none"><i>Pain Management</i><i>Uterine Services and Procedures</i> |
| 08/01/2024 | Template Update <ul style="list-style-type: none">Reformatted and reorganized policy; transferred content to new templateChanged policy type classification from “Policy Guideline” to “Medical Policy”Updated <i>Instructions for Use</i>Removed <i>Questions and Answers (Q&A)</i> section Related Policies <ul style="list-style-type: none">Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled:<ul style="list-style-type: none"><i>Pain Management</i><i>Urinary and Fecal Incontinence: Diagnosis and Treatment</i>Removed reference link to the:<ul style="list-style-type: none">UnitedHealthcare Medicare Advantage Coverage Summary titled:<ul style="list-style-type: none"><i>Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements</i><i>Gastroesophageal and Gastrointestinal (GI) Services and Procedures</i><i>Glaucoma Surgical Treatments</i><i>Radiation and Oncologic Procedures</i><i>Spine Procedures</i><i>Vision Services</i>UnitedHealthcare Commercial Medical Policy titled:<ul style="list-style-type: none"><i>Abnormal Uterine Bleeding and Uterine Fibroids</i><i>Category III Codes</i><i>Computer-Assisted Surgical Navigation for Musculoskeletal Procedures</i><i>Prolotherapy and Platelet Rich Plasma Therapies</i> |

| Date | Summary of Changes |
|------|---|
| | <p data-bbox="337 128 613 191">Coverage Rationale Overview</p> <ul data-bbox="337 201 1502 1927" style="list-style-type: none"> <li data-bbox="337 201 1502 621"> <p data-bbox="337 201 716 226">• Added language to indicate:</p> <ul data-bbox="386 228 1502 621" style="list-style-type: none"> <li data-bbox="386 228 1502 317">○ This UnitedHealthcare Medicare Advantage Medical Policy is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Medical Policies that include category III codes <li data-bbox="386 319 1502 380">○ For coverage guidelines for items and services not listed in this policy, first search the Medicare Coverage Database to confirm no applicable Medicare coverage guidelines exist <li data-bbox="386 382 1502 506">○ After searching the Medicare Coverage Database, if no National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) is found, then search for a UnitedHealthcare Medicare Advantage Medical Policy that specifically addresses the service/code; if none is found, refer to the table [listed in the policy] <li data-bbox="386 508 1502 621">○ The guidelines in this Medical Policy are for specific services only; for services not addressed in this UnitedHealthcare Medicare Advantage Medical Policy, refer to the Medicare Coverage Database to search for applicable coverage policies (NCD, LCDs and LCAs) <li data-bbox="337 623 1502 1927"> <p data-bbox="337 623 857 653">• Removed content/language addressing:</p> <ul data-bbox="386 655 1502 1927" style="list-style-type: none"> <li data-bbox="386 655 1057 684">○ Lumbar artificial disc replacement (CPT code 0165T) <li data-bbox="386 686 1295 716">○ Computer aided detection (CAD) systems (CPT codes 0174T and 0175T) <li data-bbox="386 718 1192 747">○ Evacuation of meibomian glands (CPT codes 0207T and 0563T) <li data-bbox="386 749 1354 779">○ Automated audiometry (CPT codes 0208T, 0209T, 0210T, 0211T, and 0212T) <li data-bbox="386 781 1502 842">○ Facet joint interventions (CPT codes 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0219T, 0220T, 0221T, and 0222T) <li data-bbox="386 844 1425 873">○ Transluminal peripheral atherectomy (CPT codes 0234T, 0235T, 0236T, and 0237T) <li data-bbox="386 875 1425 936">○ Carotid sinus baroreflex activation device (CPT codes 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, and 0273T) <li data-bbox="386 938 1354 968">○ Percutaneous image-guided lumbar decompression (PILD) (CPT code 0275T) <li data-bbox="386 970 862 999">○ Tear film imaging (CPT code 0330T) <li data-bbox="386 1001 1321 1031">○ Myocardial sympathetic innervation imaging (CPT codes 0331T and 0332T) <li data-bbox="386 1033 1490 1062">○ Automated visual evoked potentials (VEPS) for visual acuity screening (CPT code 0333T) <li data-bbox="386 1064 1122 1094">○ Sinus tarsi implant (CPT codes 0335T, 0510T, and 0511T) <li data-bbox="386 1096 1333 1125">○ Transcatheter renal sympathetic denervation (CPT codes 0338T and 0339T) <li data-bbox="386 1127 1040 1157">○ Transcatheter mitral valve repair (CPT code 0345T) <li data-bbox="386 1159 1393 1188">○ Radiostereometric analysis (RSA) (CPT codes 0347T, 0348T, 0349T, and 0350T) <li data-bbox="386 1190 1474 1220">○ Optical coherence tomography of breast (CPT codes 0351T, 0352T, 0353T, and 0354T) <li data-bbox="386 1222 1490 1251">○ Bioelectrical impedance analysis whole body composition assessment (CPT code 0358T) <li data-bbox="386 1253 1463 1314">○ Endoscopic retrograde cholangiopancreatography (ERCP) with optical endomicroscopy (CPT code 0397T) <li data-bbox="386 1316 1502 1377">○ Cardiac contractility modulation (CPT codes 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, and 0418T) <li data-bbox="386 1379 1117 1409">○ Drug eluting ocular inserts (CPT codes 0444T and 0445T) <li data-bbox="386 1411 964 1440">○ Retinal polarization scan (CPT codes 0469T) <li data-bbox="386 1442 1442 1472">○ Retinal prosthetic device evaluation and programming (CPT codes 0472T and 0473T) <li data-bbox="386 1474 1409 1503">○ Optical coherence tomography (OCT) of middle ear (CPT codes 0485T and 0486T) <li data-bbox="386 1505 1073 1535">○ Heterochromatic flicker photometry (CPT code 0506T) <li data-bbox="386 1537 1224 1566">○ Near-infrared dual imaging of meibomian glands (CPT code 0507T) <li data-bbox="386 1568 1474 1629">○ Wireless cardiac stimulator for left ventricular pacing (CPT codes 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0861T, 0862T, and 0863T) <li data-bbox="386 1631 1430 1692">○ Intracardiac ischemia monitoring systems (CPT codes 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, and 0532T) <li data-bbox="386 1694 1479 1755">○ Three dimensional (3D) printed anatomic models (CPT codes 0559T, 0560T, 0561T, and 0562T) <li data-bbox="386 1757 1393 1787">○ Fallopian tube occlusion with a degradable biopolymer implant (CPT code 0567T) <li data-bbox="386 1789 906 1818">○ Sonosalpingography (CPT code 0568T) <li data-bbox="386 1820 1502 1881">○ Implantable cardioverter-defibrillator system with substernal electrode (CPT codes 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, and 0580T) <li data-bbox="386 1883 1273 1913">○ Cryoablation of breast carcinoma and fibroadenoma (CPT code 0581T) <li data-bbox="386 1915 1295 1944">○ Tympanostomy (requiring insertion of ventilating tube) (CPT code 0583T) <li data-bbox="386 1946 992 1976">○ Limb lengthening procedure (CPT code 0594T) |

| Date | Summary of Changes |
|------|--|
| | <ul style="list-style-type: none"> ○ Irreversible electroporation (IRE) ablation (CPT codes 0600T and 0601T) ○ Remote monitoring of an external continuous pulmonary fluid monitoring system (CPT codes 0607T and 0608T) ○ Eye-movement analysis without spatial calibration (CPT code 0615T) ○ Iris prosthesis insertion (CPT codes 0616T, 0617T, and 0618T) ○ Hyperspectral imaging (CPT code 0631T) ○ Non-contact near-infrared spectroscopy (NIRS) (CPT codes 0640T and 0859T) ○ Magnetic gastropexy with gastrostomy tube insertion (CPT code 0647T) ○ Magnetically controlled capsule endoscopy (CPT code 0651T) ○ Electrical impedance spectroscopy for automated melanoma risk score (CPT code 0658T) ○ Intracoronary infusion of supersaturated oxygen (CPT code 0659T) ○ Donor hysterectomy (CPT codes 0664T, 0665T, 0666T, and 0667T) ○ Uterus transplantation (CPT codes 0668T, 0669T, and 0670T) ○ Aquapheresis (ultrafiltration) (CPT code 0692T) ○ Three-dimensional imaging and reconstruction of breast or axillary lymph node tissue (CPT code 0694T) ○ Electrocardiographic body surface mapping (CPT codes 0695T and 0696T) ○ Bone strength and fracture-risk assessment using digital x-ray radiogrammetry-bone mineral density (DXR-BMD) (CPT codes 0749T and 0750T) ○ Transcutaneous magnetic stimulation (TMS) (CPT codes 0766T, 0767T, 0768T, and 0769T) ○ Sacroiliac Joint Arthrodesis (CPT codes 0775T and 0809T) ○ Silver diamine fluoride for dental caries (CPT code 0792T) ● Replaced references to: <ul style="list-style-type: none"> ○ “Medically necessary [items/services]” with “reasonable and necessary [items/services]” ○ “Medically appropriate [items/services]” with “appropriate [items/services]” <p>Applicable Codes</p> <ul style="list-style-type: none"> ● Added guidelines for: <ul style="list-style-type: none"> ○ 0619T and 0867T (unproven); refer to the UnitedHealthcare Commercial Medical Policy titled <i>Prostate Surgeries and Interventions</i> ○ 0868T (unproven); refer to the UnitedHealthcare Commercial Medical Policy titled <i>Gastrointestinal Motility Disorders, Diagnosis and Treatment</i> ● Added language to indicate 0202T, 0238T, 0263T, 0264T, 0265T, 0278T, 0342T, 0422T, 0483T, 0484T, 0489T, 0490T, 0505T, 0512T, 0513T, 0543T, 0544T, 0545T, 0565T, 0566T, 0569T, 0570T, 0582T, 0598T, 0599T, 0627T, 0628T, 0629T, 0630T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0646T, 0655T, 0656T, 0657T, 0687T, 0688T, 0693T, 0704T, 0705T, 0706T, 0714T, 0717T, 0718T, 0719T, 0720T, 0737T, 0738T, 0739T, 0744T, 0778T, 0779T, 0783T, 0805T, 0806T, 0813T, 0814T, and 0858T are unproven ● Removed: <p>Non-Covered</p> <ul style="list-style-type: none"> ○ 0198T, 0329T, 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, 0436T, 0465T, 0479T, 0480T, 0533T, 0534T, 0535T, 0536T, 0552T, 0584T, 0585T, 0586T, 0641T, 0642T, 0696T, and 0743T <p>Provisional Coverage</p> <ul style="list-style-type: none"> ○ 0165T, 0275T, and 0508T ● Revised language pertaining to: <ul style="list-style-type: none"> ○ 0054T, 0055T, 0101T, 0102T, and 0232T; updated instruction to refer to the UnitedHealthcare Commercial Medical Policy titled <i>Orthopedic Procedures, Devices, and Products</i> ○ 0071T and 0072T; updated instruction to refer to the UnitedHealthcare Medicare Advantage Medical Policy titled <i>Uterine Services and Procedures</i> ○ 0100T; added instruction to: <ul style="list-style-type: none"> ▪ Refer to the listed LCDs/LCAs ▪ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled <i>Omnibus Codes</i> ○ 0202T; added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled <i>Spinal Fusion and Decompression</i> |

| Date | Summary of Changes |
|------|---|
| | <ul style="list-style-type: none"> ○ 0440T, 0441T, and 0442T; added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled <i>Pain Management</i> ○ 0672T; added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled <i>Urinary and Fecal Incontinence: Diagnosis and Treatment</i> ● Revised description for 0054T, 0055T, and 0714T <p>Centers for Medicare & Medicaid Services (CMS) Related Documents</p> <ul style="list-style-type: none"> ● Updated list of documents available in the <i>Medicare Coverage Database</i> to reflect the most current information ● Added list of applicable <i>Medicare Administrative Contractors (MACS) with Corresponding States/Territories</i> <p>Supporting Information</p> <ul style="list-style-type: none"> ● Archived previous policy version MPG043.39 |

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

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

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

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

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.