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

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Contractor Information

Contractor Name
Noridian Healthcare Solutions, LLC
Contract Number
01112
Contract Type
A and B MAC
Jurisdiction
J - E

LCD Information

Document Information

LCD ID
L36219

Original ICD-9 LCD ID
N/A

LCD Title
Non Covered Services

Jurisdiction
California - Northern

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 10/01/2015

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

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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.

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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 for a specific indication does not, in itself, make the procedure medically reasonable and necessary. Noridian evaluates new services, procedures, drugs or technology and considers national and local policies before these new services may be considered Medicare covered services.

This LCD contains listings of numerous non-covered services which have no specific CPT code. Adding difficulty to correct coding for such services is the fact that there are many where two or more specific unlisted codes could arguably be used to designate the service. Initial preparation of the LCD to cover every possible code use – and more importantly, maintenance of the LCD as code changes occur – is difficult if not impossible.

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

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

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

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

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

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

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**Coding Information**

Bill Type Codes:

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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.

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)
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.

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

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CPT/HCPCS Codes

Group 1 Paragraph: Noridian Non-Coverage Determinations:

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

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

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

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

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

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

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

- Accu-Spina
- Analysis of patient-specific findings with quantifiable computer probability assessment, including report
- Antiprothrombin (phospholipid cofactor) antibody, each IG class
- Bile duct extracorporeal shock-wave lithotripsy
- Breast ductoscopy
- BSGI, Breast Scintography
- Carbon monoxide, expired gas analysis [e.g. ETCO/hemolysis breath test]
- Circular boot treatment
- Clinical drug interaction testing
- Coblation debridement of tendon and/or fascia
- CT fusion
- Decision DX-LEA Test
- Decision DX-UM 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

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Leukocytes, stool
Lipoprotein, direct measurement, intermediate density lipoproteins [IDL][remnant lipoprotein]
Lung spectroscopy
Mammary duct(s) catheter lavage
Medialization thyroplasty
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
Speculoscop[y, including sampling
Splint mouth guard or night guard
Sublingual antigen drops
Suprachoroidal delivery of pharmacologic agent
Therabite appliance dispensed due to trismus
Therapy using Superluminous Diodes
Transcranial stimulation for depression
Transoral Incisionless Fundoplication
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 Ag

*NOTE: NCD 150.10 prohibits payment for individuals over 60 years of age for the following CPT/HCPCS codes: 22856, 22857, 22858, 22861, 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:**

TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYCTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION); SINGLE INTERSPACE, CERVICAL

TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR

TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYCTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION); SECOND LEVEL, CERVICAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL

REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR

OPEN OSTEochondral autograft, talus (INCLUDES OBTAINING GRAFT[S])
ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE PULMONARY TUMOR(S)
INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, RADIOFREQUENCY, UNILATERAL

34806
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43257</td>
<td>TRANSCATHETER PLACEMENT OF WIRELESS PHYSIOLOGIC SENSOR IN ANEURYSMAL SAC DURING ENDOVASCULAR REPAIR, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION, INSTRUMENT CALIBRATION, AND COLLECTION OF PRESSURE DATA (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>46707</td>
<td>REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])</td>
</tr>
<tr>
<td>62263</td>
<td>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</td>
</tr>
<tr>
<td>62264</td>
<td>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</td>
</tr>
<tr>
<td>62287</td>
<td>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 THE USE OF AN ENDOSCOPE, WITH DISCOGRAPHY AND/OR EPIDURAL INJECTION(S) AT THE TREATED LEVEL(S), WHEN PERFORMED, SINGLE OR MULTIPLE LEVELS, LUMBAR</td>
</tr>
<tr>
<td>82172</td>
<td>APOLIPOPROTEIN, EACH</td>
</tr>
<tr>
<td>83698</td>
<td>LIPOPROTEIN-ASSOCIATED PHOSPHOLIPASE A2 (LP-PLA2)</td>
</tr>
<tr>
<td>83987</td>
<td>PH; EXHALED BREATH CONDENSATE</td>
</tr>
<tr>
<td>84145</td>
<td>PROCALCITONIN (PCT)</td>
</tr>
<tr>
<td>84431</td>
<td>THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE</td>
</tr>
<tr>
<td>86305</td>
<td>HUMAN EPIDIDYMIS PROTEIN 4 (HE4)</td>
</tr>
<tr>
<td>86352</td>
<td>CELLULAR FUNCTION ASSAY INVOLVING STIMULATION (EG, MITOGEN OR ANTIGEN) AND DETECTION OF BIOMARKER (EG, ATP)</td>
</tr>
<tr>
<td>90867</td>
<td>THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, DELIVERY AND MANAGEMENT</td>
</tr>
<tr>
<td>90868</td>
<td>THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION</td>
</tr>
<tr>
<td>90869</td>
<td>THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT MOTOR THRESHOLD RE-DETERMINATION WITH DELIVERY AND MANAGEMENT</td>
</tr>
<tr>
<td>91132</td>
<td>ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS;</td>
</tr>
<tr>
<td>91133</td>
<td>ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS; WITH PROVOCATIVE TESTING</td>
</tr>
<tr>
<td>92145</td>
<td>CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT</td>
</tr>
<tr>
<td>93702</td>
<td>BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)</td>
</tr>
<tr>
<td>93982</td>
<td>FOLLOWING ENDOVASCULAR REPAIR, COMPLETE STUDY INCLUDING RECORDING, ANALYSIS OF PRESSURE AND WAVEFORM TRACINGS, INTERPRETATION AND REPORT</td>
</tr>
<tr>
<td>97026</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED</td>
</tr>
<tr>
<td>97033</td>
<td>APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES</td>
</tr>
<tr>
<td>972010</td>
<td>INJECTION, LINCOMYCIN HCL, UP TO 300 MG</td>
</tr>
<tr>
<td>J7330</td>
<td>AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT</td>
</tr>
<tr>
<td>0091T</td>
<td>EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED, LOW ENERGY</td>
</tr>
<tr>
<td>0042T</td>
<td>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</td>
</tr>
<tr>
<td>0054T</td>
<td>COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>0055T</td>
<td>COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON CT/MRI IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>0071T</td>
<td>FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME LESS THAN 200 CC OF TISSUE</td>
</tr>
<tr>
<td>0072T</td>
<td>FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME GREATER OR EQUAL TO 200 CC OF TISSUE</td>
</tr>
<tr>
<td>0098T</td>
<td></td>
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</tbody>
</table>
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 INTRA-OCULAR 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

0103T HOLOTRANS Cobalamin, Quantitative

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

0123T FISTULIZATION OF SCLERA FOR GLAUCOMA, THROUGH CILIARY BODY

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 DISC), ANTERIOR APPROACH, EACH ADDITIONAL INTERSPACE, LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0169T STEREOTACTIC PLACEMENT OF INFUSION CATHETER(S) IN THE BRAIN FOR DELIVERY OF THERAPEUTIC AGENT(S), INCLUDING COMPUTERIZED STEREOTACTIC PLANNING AND BURR HOLE(S)

0190T PLACEMENT OF INTRAOCULAR RADIATION SOURCE APPLICATOR (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)

0195T ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, DISC SPACE PREPARATION, DISCECTOMY, WITHOUT INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED; L5-S1 INTERSPACE

0196T ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, DISC SPACE PREPARATION, DISCECTOMY, WITHOUT INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED; L4-L5 INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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

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

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

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

0219T PLACEMENT OF A POSTERIOR INTRA FACET 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 INTRA FACET 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 INTRA FACET 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 INTRA FACET 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)
INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED

0233T SKIN ADVANCED GLYcation ENDPRODUCTS (AGE) MEASUREMENT BY MULTI-WAVELENGTH FLuorescent SPECTROscopy

0234T TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLoGICAL SUPERVISION AND INTERPRETATION; RENAL ARTERY

0235T TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLoGICAL SUPERVISION AND INTERPRETATION; VISCERAL ARTERY (EXCEPT RENAL), EACH VESSEL

0236T TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLoGICAL SUPERVISION AND INTERPRETATION; ABDOMINAL AORTA

0237T TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLoGICAL SUPERVISION AND INTERPRETATION; BRACHIOCEPHALIC TRUNK AND BRANCHES, EACH VESSEL

0238T TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLoGICAL SUPERVISION AND INTERPRETATION; ILIAC ARTERY, EACH VESSEL

ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY WITH INTERPRETATION AND REPORT; WITH HIGH RESOLUTION ESOPHAGEAL PRESSURE TOPOGRAPHY

ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY WITH INTERPRETATION AND REPORT; WITH STIMULATION OR PERFUSION DURING HIGH RESOLUTION ESOPHAGEAL PRESSURE TOPOGRAPHY STUDY (EG, STIMULANT, ACID OR ALKALI PERFUSION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0243T INTERMITTENT MEASUREMENT OF WHEEZE RATE FOR BRONCHODILATOR OR BRONCHIAL-CHALLENGE DIAGNOSTIC EVALUATION(S), WITH INTERPRETATION AND REPORT

0244T CONTINUOUS MEASUREMENT OF WHEEZE RATE DURING TREATMENT ASSESSMENT OR DURING SLEEP FOR DOCUMENTATION OF NOCTURNAL WHEEZE AND COUGH FOR DIAGNOSTIC EVALUATION 3 TO 24 HOURS, WITH INTERPRETATION AND REPORT

0253T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE

ENDOVASCULAR REPAIR OF IliAC ARTERY BIFURCATION (EG, ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA) USING BIFURCATED ENDOPROSTHESIS FROM THE COMMON IliAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL IliAC ARTERY, UNILATERAL;

0254T ENDOVASCULAR REPAIR OF IliAC ARTERY BIFURCATION (EG, ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA) USING BIFURCATED ENDOPROSTHESIS FROM THE COMMON IliAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL IliAC ARTERY, UNILATERAL; RADIOLoGICAL SUPERVISION AND INTERPRETATION

0255T 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

0263T 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

0264T UNILATERAL OR BILATERAL BONE MARROW HARVEST ONLY FOR INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY

0265T 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)

0266T IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; LEAD ONLY, UNILATERAL (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)

0267T IMPLANTATION OR REPLACEMENT OF CAROTID SINUS BAROREFLEX ACTIVATION DEVICE; PULSE GENERATOR ONLY (INCLUDES INTRA-OPERATIVE INTERROGATION, PROGRAMMING, AND REPOSITIONING, WHEN PERFORMED)

INTERROGATION DEVICE EVALUATION (IN PERSON), CAROTID SINUS BAROREFLEX ACTIVATION SYSTEM, INCLUDING TELMETRIC ITERATIVE COMMUNICATION WITH THE IMPLANTABLE DEVICE TO MONITOR DEVICE DIAGNOSTICS AND PROGRAMMED THERAPY VALUES, WITH INTERPRETATION AND REPORT (EG, BATTERY STATUS, LEAD IMPEDANCE, PULSE AMPLITUDE, PULSE WIDTH, THERAPY FREQUENCY, PATHWAY MODE, BURST MODE, THERAPY START/STOP TIMES EACH DAY)
INTERROGATION DEVICE EVALUATION (IN PERSON), CAROTID SINUS BAROREFLEX ACTIVATION SYSTEM, INCLUDING TELEMETRIC ITERATIVE COMMUNICATION WITH THE IMPLANTABLE DEVICE TO MONITOR DEVICE DIAGNOSTICS AND PROGRAMMED THERAPY VALUES, WITH INTERPRETATION AND REPORT (EG, BATTERY STATUS, LEAD IMPEDANCE, PULSE AMPLITUDE, PULSE WIDTH, THERAPY FREQUENCY, PATHWAY MODE, BURST MODE, THERAPY START/STOP TIMES EACH DAY); WITH PROGRAMMING

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), WITH OR WITHOUT THE USE OF AN ENDOSCOPE, SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; CERVICAL OR THORACIC

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), WITH OR WITHOUT THE USE OF AN ENDOSCOPE, SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; LUMBAR

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

NEAR-IRFARED SPECTROSCOPY STUDIES OF LOWER EXTREMITY WOUNDS (EG, FOR OXYHEMOGLOBIN MEASUREMENT)

NEAR-IRFARED GUIDANCE FOR VASCULAR ACCESS REQUIRING REAL-TIME DIGITAL VISUALIZATION OF SUBCUTANEOUS VASCULATURE FOR EVALUATION OF POTENTIAL ACCESS SITES AND VESSEL PATENCY

ANOSCOPY, WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF THE ANAL CANAL (EG, FOR FECAL INCONTINENCE)

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

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)

INTRAVASCULAR OPTICAL COHERENCE TOMOGRAPHY (CORONARY NATIVE VESSEL OR GRAFT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)

INTRAVASCULAR OPTICAL COHERENCE TOMOGRAPHY (CORONARY NATIVE VESSEL OR GRAFT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)

INSERTION OF LEFT ATRIAL HEMODYNAMIC MONITOR; COMPLETE SYSTEM, INCLUDES IMPLANTED COMMUNICATION MODULE AND PRESSURE SENSOR LEAD IN LEFT ATRIUM INCLUDING TRANSSEPTAL ACCESS, RADIOLOGICAL SUPERVISION AND INTERPRETATION, AND ASSOCIATED INJECTION PROCEDURES, WHEN PERFORMED

INSERTION OF LEFT ATRIAL HEMODYNAMIC MONITOR; PRESSURE SENSOR LEAD AT TIME OF INSERTION OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION AND ASSOCIATED INJECTION PROCEDURES, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, HIGH ENERGY, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; INITIAL WOUND

EXTRACORPORREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, HIGH ENERGY, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; EACH ADDITIONAL WOUND (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

DESTRUCTION/REDUCTION OF MALIGNANT BREAST TUMOR WITH EXTERNALLY APPLIED FOCUSED MICROWAVE, INCLUDING INTERSTITIAL PLACEMENT OF DISPOSABLE CATHETER WITH COMBINED TEMPERATURE MONITORING PROBE AND MICROWAVE FOCUSING SENSOCATHETER UNDER ULTRASOUND THERMOTHERAPY GUIDANCE

INSERTION OR REMOVAL AND REPLACEMENT OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM INCLUDING IMAGING SUPERVISION AND INTERPRETATION WHEN PERFORMED AND INTRA-OPERATIVE INTERROGATION AND PROGRAMMING WHEN PERFORMED; COMPLETE SYSTEM (INCLUDES DEVICE AND ELECTRODE)
INSERTION OR REMOVAL AND REPLACEMENT OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM INCLUDING IMAGING SUPERVISION AND INTERPRETATION WHEN PERFORMED AND INTRA-OPERATIVE INTERROGATION AND PROGRAMMING WHEN PERFORMED; ELECTRODE ONLY

0304T INSERTION OR REMOVAL AND REPLACEMENT OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM INCLUDING IMAGING SUPERVISION AND INTERPRETATION WHEN PERFORMED AND INTRA-OPERATIVE INTERROGATION AND PROGRAMMING WHEN PERFORMED; DEVICE ONLY

0305T PROGRAMMING DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ITERATIVE ADJUSTMENT OF PROGRAMMED VALUES, WITH ANALYSIS, REVIEW, AND REPORT

0306T INTERROGATION DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ANALYSIS, REVIEW, AND REPORT

0310T MOTOR FUNCTION MAPPING USING NON-INVASIVE NAVIGATED TRANSCRANIAL MAGNETIC STIMULATION (NTMS) FOR THERAPEUTIC TREATMENT PLANNING, UPPER AND LOWER EXTREMITY

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

0333T VISUAL EVOKED POTENTIAL, SCREENING OF VISUAL ACUITY, AUTOMATED

0335T EXTRA-OSSEOUS SUBTALAR JOINT IMPLANT FOR TALOTARSAL STABILIZATION ENDOTHELIAL FUNCTION ASSESSMENT, USING PERIPHERAL VASCULAR RESPONSE TO REACTIVE HYPEREMIA, NON-INVASIVE (EG, BRACHIAL ARTERY ULTRASOUND, PERIPHERAL ARTERY TONOMETRY), UNILATERAL OR BILATERAL

0337T 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 AORTOGRAPH 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 AORTOGRAPH AND DIAGNOSTIC RENAL ANGIOGRAPHY WHEN PERFORMED; BILATERAL

0340T ABLATION, PULMONARY TUMOR(S), INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, CRYOABLATION, UNILATERAL, INCLUDES IMAGING GUIDANCE

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

0342T THERAPEUTIC APHERESIS WITH SELECTIVE HDL DELIPIDATION AND PLASMA REINFUSION

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

0347T PLACEMENT OF INTERSTITIAL DEVICE(S) IN BONE FOR RADIOSTEREOMETRIC ANALYSIS (RSA)

0348T RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); SPINE, (INCLUDES CERVICAL, THORACIC AND LUMBOSACRAL, WHEN PERFORMED)

0349T RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); UPPER EXTREMITY(IES), (INCLUDES SHOULDER, ELBOW, AND WRIST, WHEN PERFORMED)

0350T RADIOLOGIC EXAMINATION, RADIOSTEREOMETRIC ANALYSIS (RSA); LOWER EXTREMITY(IES), (INCLUDES HIP, PROXIMAL FEMUR, KNEE, AND ANKLE, WHEN PERFORMED)

0351T OPTICAL COHERENCE TOMOGRAPHY OF BREAST OR AXILLARY LYMPH NODE, EXCISED TISSUE, EACH SPECIMEN; REAL-TIME INTRAOPERATIVE

0352T OPTICAL COHERENCE TOMOGRAPHY OF BREAST OR AXILLARY LYMPH NODE, EXCISED TISSUE, EACH SPECIMEN; INTERPRETATION AND REPORT, REAL-TIME OR REFERRED

0353T OPTICAL COHERENCE TOMOGRAPHY OF BREAST, SURGICAL CAVITY; REAL-TIME INTRAOPERATIVE

0354T OPTICAL COHERENCE TOMOGRAPHY OF BREAST, SURGICAL CAVITY; INTERPRETATION AND REPORT, REAL-TIME OR REFERRED
GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), COLON, WITH INTERPRETATION AND REPORT

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

CRYOPRESERVATION; IMMATURE OOCYTE(S)

BIOELECTRICAL IMPEDANCE ANALYSIS WHOLE BODY COMPOSITION ASSESSMENT, SUPINE POSITION, WITH INTERPRETATION AND REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXPOSURE ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION REQUIRING TWO OR MORE TECHNICIANS FOR SEVERE MALADAPTIVE BEHAVIOR(S); FIRST 60 MINUTES OF TECHNICIANS' TIME, FACE-TO-FACE WITH PATIENT

EXPOSURE ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION REQUIRING TWO OR MORE TECHNICIANS FOR SEVERE MALADAPTIVE BEHAVIOR(S); EACH ADDITIONAL 30 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH PATIENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYTETECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), CERVICAL, THREE OR MORE LEVELS

INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE TRABECULAR MESHWORK; EACH ADDITIONAL DEVICE INSERTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING UP TO 14 DAYS TO ASSESS CHANGES IN HEART RATE AND TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL.

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

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.

TRANSCATHETER INSERTION OR REPLACEMENT OF PERMANENT LEADLESS PACEMAKER, VENTRICULAR

TRANSCATHETER REMOVAL OF PERMANENT LEADLESS PACEMAKER, VENTRICULAR

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, LEADLESS PACEMAKER SYSTEM

PERI-PROCEDURAL DEVICE EVALUATION (IN PERSON) AND PROGRAMMING OF DEVICE SYSTEM

PARAMETERS BEFORE OR AFTER A SURGERY, PROCEDURE OR TEST WITH ANALYSIS, REVIEW AND REPORT, LEADLESS PACEMAKER SYSTEM

INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER, LEADLESS PACEMAKER SYSTEM

LAPAROSCOPY, SURGIVAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND)

0392T REMOVAL OF ESOPHAGEAL SPHINCTER AUGMENTATION DEVICE

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:**

0126T  COMMON CAROTID INTIMA-MEDIA THICKNESS (IMT) STUDY FOR EVALUATION OF ATHEROSCLEROTIC BURDEN OR CORONARY HEART DISEASE RISK FACTOR ASSESSMENT

0159T  COMPUTER-AIDED DETECTION, INCLUDING COMPUTER ALGORITHM ANALYSIS OF MRI IMAGE DATA FOR LESION DETECTION/CHARACTERIZATION, PHARMACOKINETIC ANALYSIS, WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, BREAST MRI (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0174T  WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFORMED CONCURRENT WITH PRIMARY INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0175T  WITH 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

0223T  ACOUSTIC CARDIOGRAPHY, INCLUDING AUTOMATED ANALYSIS OF COMBINED ACOUSTIC AND ELECTRICAL INTERVALS; SINGLE, WITH INTERPRETATION AND REPORT

0224T  ACOUSTIC CARDIOGRAPHY, INCLUDING AUTOMATED ANALYSIS OF COMBINED ACOUSTIC AND ELECTRICAL INTERVALS; MULTIPLE, INCLUDING SERIAL TRENDED ANALYSIS AND LIMITED REPROGRAMMING OF DEVICE PARAMETER, AV OR VV DELAYS ONLY, WITH INTERPRETATION AND REPORT

0225T  ACOUSTIC CARDIOGRAPHY, INCLUDING AUTOMATED ANALYSIS OF COMBINED ACOUSTIC AND ELECTRICAL INTERVALS; MULTIPLE, INCLUDING SERIAL TRENDED ANALYSIS AND LIMITED REPROGRAMMING OF DEVICE PARAMETER, AV AND VV DELAYS, WITH INTERPRETATION AND REPORT

0311T  NON-INVASIVE CALCULATION AND ANALYSIS OF CENTRAL ARTERIAL PRESSURE WAVEFORMS WITH INTERPRETATION AND REPORT

**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:**

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

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

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

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** XXX00 Not Applicable

**Group 1 Codes:**

**ICD-10 Codes** | **Description**
--- | ---
XX000 | Not Applicable

ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information

**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.

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Sources of Information and Basis for Decision
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


Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 09/11/2015 with effective dates 10/01/2015 - N/A Updated on 06/19/2015 with effective dates 10/01/2015 - N/A Updated on 06/04/2015 with effective dates 10/01/2015 - N/A Updated on 05/26/2015 with effective dates 10/01/2015 - N/A

Keywords

• Non Covered Services

Read the LCD Disclaimer Back to Top