

Local Coverage Determination (LCD): Non-Covered Services (L35008)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Noridian Healthcare Solutions, LLC	A and B MAC	02101 - MAC A	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02102 - MAC B	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02201 - MAC A	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02202 - MAC B	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02301 - MAC A	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02302 - MAC B	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02401 - MAC A	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	02402 - MAC B	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	03101 - MAC A	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03102 - MAC B	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03201 - MAC A	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03202 - MAC B	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03301 - MAC A	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03302 - MAC B	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03401 - MAC A	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03402 - MAC B	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03501 - MAC A	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03502 - MAC B	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03601 - MAC A	J - F	Wyoming
Noridian Healthcare Solutions, LLC	A and B MAC	03602 - MAC B	J - F	Wyoming

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LCD Information

Document Information

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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.

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.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally

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 and Devices - Supplies Incident to Radiology
0622 Medical/Surgical Supplies and Devices - Supplies Incident to Other DX Services
0623 Medical/Surgical Supplies and Devices - Surgical Dressings
0624 Medical/Surgical Supplies and Devices - FDA Investigational Devices
0631 Pharmacy - Single Source Drug
0632 Pharmacy - Multiple Source Drug
0633 Pharmacy - Restrictive Prescription
0636 Pharmacy - Drugs Requiring Detailed Coding
073X EKG/ECG (Electrocardiogram) - General Classification

0740 EEG (Electroencephalogram) - General Classification
0750 Gastro-Intestinal (GI) Services - General Classification
076X Specialty Services - General Classification
0790 Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) - General Classification
0900 Behavioral Health Treatment/Services - General Classification
092X Other Diagnostic Services - General Classification
094X Other Therapeutic Services - General Classification

CPT/HCPCS Codes

Group 1 Paragraph:

Noridian Non-Coverage Determinations:

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

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

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

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

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

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

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

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

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

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

Group 1 Codes:

- 22857 TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR
- 22862 REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR
- 28446 OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT[S])
- 32998 ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL; RADIOFREQUENCY
- 43257 ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF LOWER ESOPHAGEAL SPHINCTER AND/OR GASTRIC CARDIA, FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
- 43284 LAPAROSCOPY, SURGICAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND), INCLUDING CRUROPLASTY WHEN PERFORMED
- 43285 REMOVAL OF ESOPHAGEAL SPHINCTER AUGMENTATION DEVICE
- 46707 REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])
- 62263 PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 2 OR MORE DAYS
- 62264 PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 1 DAY
- 62287

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

- 83987 PH; EXHALED BREATH CONDENSATE
- 84145 PROCALCITONIN (PCT)
- 84431 THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE
- 86305 HUMAN EPIDIDYMIS PROTEIN 4 (HE4)
- 91132 ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS;
- 91133 ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS; WITH PROVOCATIVE TESTING
- 92145 CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
- 93702 BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)
- 97026 APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
- 97033 APPLICATION OF A MODALITY TO 1 OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
- J2010 INJECTION, LINCOMYCIN HCL, UP TO 300 MG
- J7330 AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT
CEREBRAL PERFUSION ANALYSIS USING COMPUTED TOMOGRAPHY WITH CONTRAST ADMINISTRATION,
- 0042T INCLUDING POST-PROCESSING OF PARAMETRIC MAPS WITH DETERMINATION OF CEREBRAL BLOOD FLOW, CEREBRAL BLOOD VOLUME, AND MEAN TRANSIT TIME
COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH
- 0054T IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH
- 0055T IMAGE-GUIDANCE BASED ON CT/MRI IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0071T FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME LESS THAN 200 CC OF TISSUE
- 0072T FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME GREATER OR EQUAL TO 200 CC OF TISSUE
- 0098T REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, EACH ADDITIONAL INTERSPACE, CERVICAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0100T PLACEMENT OF A SUBCONJUNCTIVAL RETINAL PROSTHESIS RECEIVER AND PULSE GENERATOR, AND IMPLANTATION OF INTRAOCULAR RETINAL ELECTRODE ARRAY, WITH VITRECTOMY
- 0101T EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED, HIGH ENERGY
- 0102T EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN, REQUIRING ANESTHESIA OTHER THAN LOCAL, INVOLVING LATERAL HUMERAL EPICONDYLE
- 0106T QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING TOUCH PRESSURE STIMULI TO ASSESS LARGE DIAMETER SENSATION
- 0107T QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING VIBRATION STIMULI TO ASSESS LARGE DIAMETER FIBER SENSATION
- 0108T QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING COOLING STIMULI TO ASSESS SMALL NERVE FIBER SENSATION AND HYPERALGESIA
- 0109T QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING HEAT -PAIN STIMULI TO ASSESS SMALL NERVE FIBER SENSATION AND HYPERALGESIA
- 0110T QUANTITATIVE SENSORY TESTING (QST), TESTING AND INTERPRETATION PER EXTREMITY; USING OTHER STIMULI TO ASSESS SENSATION
- 0111T LONG-CHAIN (C20-22) OMEGA-3 FATTY ACIDS IN RED BLOOD CELL (RBC) MEMBRANES
TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO
- 0163T PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), EACH ADDITIONAL INTERSPACE, LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR
- 0165T APPROACH, EACH ADDITIONAL INTERSPACE, LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0190T PLACEMENT OF INTRAOCULAR RADIATION SOURCE APPLICATOR (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)
ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, DISC SPACE PREPARATION, DISCECTOMY,
- 0195T WITHOUT INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED; L5-S1 INTERSPACE

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

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

0202T POSTERIOR VERTEBRAL JOINT(S) ARTHROPLASTY (EG, FACET JOINT[S] REPLACEMENT), INCLUDING FACETECTOMY, LAMINECTOMY, FORAMINOTOMY, AND VERTEBRAL COLUMN FIXATION, INJECTION OF BONE CEMENT, WHEN PERFORMED, INCLUDING FLUOROSCOPY, SINGLE LEVEL, LUMBAR SPINE INTRAVASCULAR CATHETER-BASED CORONARY VESSEL OR GRAFT SPECTROSCOPY (EG, INFRARED)

0205T DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT, EACH VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0206T COMPUTERIZED DATABASE ANALYSIS OF MULTIPLE CYCLES OF DIGITIZED CARDIAC ELECTRICAL DATA FROM TWO OR MORE ECG LEADS, INCLUDING TRANSMISSION TO A REMOTE CENTER, APPLICATION OF MULTIPLE NONLINEAR MATHEMATICAL TRANSFORMATIONS, WITH CORONARY ARTERY OBSTRUCTION SEVERITY ASSESSMENT

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

0219T PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL

0220T PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC

0221T PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR

0222T PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0232T INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED

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

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

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

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

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

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

0254T ENDOVASCULAR REPAIR OF ILIAC ARTERY BIFURCATION (EG, ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA, DISSECTION) USING BIFURCATED ENDOGRAFT FROM THE COMMON ILIAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL ILIAC ARTERY, INCLUDING ALL SELECTIVE AND/OR NONSELECTIVE CATHETERIZATION(S) REQUIRED FOR DEVICE PLACEMENT AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, UNILATERAL

0263T INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; COMPLETE PROCEDURE INCLUDING UNILATERAL OR BILATERAL BONE MARROW HARVEST

0264T INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; COMPLETE PROCEDURE EXCLUDING BONE MARROW HARVEST

0265T INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY, WITH PREPARATION OF HARVESTED CELLS, MULTIPLE INJECTIONS, ONE LEG, INCLUDING ULTRASOUND GUIDANCE, IF PERFORMED; UNILATERAL OR BILATERAL BONE MARROW HARVEST ONLY FOR INTRAMUSCULAR AUTOLOGOUS BONE MARROW CELL THERAPY

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

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

0268T

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

INTERROGATION DEVICE EVALUATION (IN PERSON), CAROTID SINUS BAROREFLEX ACTIVATION SYSTEM, INCLUDING TELEMETRIC ITERATIVE COMMUNICATION WITH THE IMPLANTABLE DEVICE TO

0272T 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

0273T 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 LIGAMENOUS RESECTION, DISCECTOMY, FACETECTOMY AND/OR FORAMINOTOMY), ANY METHOD, UNDER INDIRECT IMAGE GUIDANCE (EG, FLUOROSCOPIC, CT), SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; CERVICAL OR THORACIC

0274T

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

0278T

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)

0290T

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

0312T

VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC REVISION OR REPLACEMENT OF

0313T VAGAL TRUNK NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR

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

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

0329T MONITORING OF INTRAOCULAR PRESSURE FOR 24 HOURS OR LONGER, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT

0330T TEAR FILM IMAGING, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT

0331T MYOCARDIAL SYMPATHETIC INNERVATION IMAGING, PLANAR QUALITATIVE AND QUANTITATIVE ASSESSMENT;

0332T MYOCARDIAL SYMPATHETIC INNERVATION IMAGING, PLANAR QUALITATIVE AND QUANTITATIVE ASSESSMENT; WITH TOMOGRAPHIC SPECT

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

0335T EXTRA-OSSEOUS SUBTALAR JOINT IMPLANT FOR TALOTARSAL STABILIZATION

ENDOTHELIAL FUNCTION ASSESSMENT, USING PERIPHERAL VASCULAR RESPONSE TO REACTIVE

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

TRANSCATHETER RENAL SYMPATHETIC DENERVATION, PERCUTANEOUS APPROACH INCLUDING ARTERIAL PUNCTURE, SELECTIVE CATHETER PLACEMENT(S) RENAL ARTERY(IES), FLUOROSCOPY,

0338T CONTRAST INJECTION(S), INTRAPROCEDURAL ROADMAPING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE GRADIENT MEASUREMENTS, FLUSH AORTOGRAM AND DIAGNOSTIC RENAL ANGIOGRAPHY WHEN PERFORMED; UNILATERAL

TRANSCATHETER RENAL SYMPATHETIC DENERVATION, PERCUTANEOUS APPROACH INCLUDING ARTERIAL PUNCTURE, SELECTIVE CATHETER PLACEMENT(S) RENAL ARTERY(IES), FLUOROSCOPY,

0339T CONTRAST INJECTION(S), INTRAPROCEDURAL ROADMAPING AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE GRADIENT MEASUREMENTS, FLUSH AORTOGRAM AND DIAGNOSTIC RENAL ANGIOGRAPHY WHEN PERFORMED; BILATERAL

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

0342T THERAPEUTIC APHERESIS WITH SELECTIVE HDL DELIPIDATION AND PLASMA REINFUSION

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

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

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

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

0350T

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

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

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

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

0354T OPTICAL COHERENCE TOMOGRAPHY OF BREAST, SURGICAL CAVITY; INTERPRETATION AND REPORT, REAL-TIME OR REFERRED

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

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

0357T CRYOPRESERVATION; IMMATURE OOCYTE(S)

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

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

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

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

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

0363T EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT, INCLUDES PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL 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)

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

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

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

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

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

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

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

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

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

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

0374T

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

0375T TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), CERVICAL, THREE OR MORE LEVELS

0376T INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE TRABECULAR MESHWORK; EACH ADDITIONAL DEVICE INSERTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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

0382T EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING UP TO 14 DAYS TO ASSESS CHANGES IN HEART RATE AND TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REVIEW AND INTERPRETATION ONLY

0383T EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING FROM 15 TO 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

0384T EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING FROM 15 TO 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REVIEW AND INTERPRETATION ONLY

0385T EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING MORE THAN 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

0386T EXTERNAL HEART RATE AND 3-AXIS ACCELEROMETER DATA RECORDING MORE THAN 30 DAYS TO ASSESS CHANGES IN HEART RATE TO MONITOR MOTION ANALYSIS FOR THE PURPOSES OF DIAGNOSING NOCTURNAL EPILEPSY SEIZURE EVENTS; INCLUDES REPORT, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REVIEW AND INTERPRETATION ONLY

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

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

0398T MAGNETIC RESONANCE IMAGE GUIDED HIGH INTENSITY FOCUSED ULTRASOUND (MRGFUS), STEREOTACTIC ABLATION LESION, INTRACRANIAL FOR MOVEMENT DISORDER INCLUDING STEREOTACTIC NAVIGATION AND FRAME PLACEMENT WHEN PERFORMED

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

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

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

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

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

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

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

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

0411T

INSERTION OR REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM, INCLUDING CONTRACTILITY EVALUATION WHEN PERFORMED, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; VENTRICULAR ELECTRODE ONLY
 0412T REMOVAL OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM; PULSE GENERATOR ONLY
 0413T REMOVAL OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM; TRANSVENOUS ELECTRODE (ATRIAL OR VENTRICULAR)
 0414T REMOVAL AND REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM PULSE GENERATOR ONLY
 0415T REPOSITIONING OF PREVIOUSLY IMPLANTED CARDIAC CONTRACTILITY MODULATION TRANSVENOUS ELECTRODE (ATRIAL OR VENTRICULAR LEAD)
 0416T RELOCATION OF SKIN POCKET FOR IMPLANTED CARDIAC CONTRACTILITY MODULATION PULSE GENERATOR
 PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, INCLUDING REVIEW AND REPORT, IMPLANTABLE CARDIAC CONTRACTILITY MODULATION SYSTEM
 0417T INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER, IMPLANTABLE CARDIAC CONTRACTILITY MODULATION SYSTEM
 0418T DESTRUCTION OF NEUROFIBROMA, EXTENSIVE (CUTANEOUS, DERMAL EXTENDING INTO SUBCUTANEOUS); FACE, HEAD AND NECK, GREATER THAN 50 NEUROFIBROMAS
 0419T DESTRUCTION OF NEUROFIBROMA, EXTENSIVE (CUTANEOUS, DERMAL EXTENDING INTO SUBCUTANEOUS); TRUNK AND EXTREMITIES, EXTENSIVE, GREATER THAN 100 NEUROFIBROMAS
 0420T TRANSURETHRAL WATERJET ABLATION OF PROSTATE, INCLUDING CONTROL OF POST-OPERATIVE BLEEDING, INCLUDING ULTRASOUND GUIDANCE, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED WHEN PERFORMED)
 0421T TACTILE BREAST IMAGING BY COMPUTER-AIDED TACTILE SENSORS, UNILATERAL OR BILATERAL
 0422T SECRETORY TYPE II PHOSPHOLIPASE A2 (SPLA2-IIA)
 0423T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; COMPLETE SYSTEM (TRANSVENOUS PLACEMENT OF RIGHT OR LEFT STIMULATION LEAD, SENSING LEAD, IMPLANTABLE PULSE GENERATOR)
 0424T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
 0425T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
 0426T INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY
 0427T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; PULSE GENERATOR ONLY
 0428T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
 0429T REMOVAL OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
 0430T REMOVAL AND REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA, PULSE GENERATOR ONLY
 0431T REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; STIMULATION LEAD ONLY
 0432T REPOSITIONING OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; SENSING LEAD ONLY
 0433T INTERROGATION DEVICE EVALUATION IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA
 0434T PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; SINGLE SESSION
 0435T PROGRAMMING DEVICE EVALUATION OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM FOR CENTRAL SLEEP APNEA; DURING SLEEP STUDY
 0436T MYOCARDIAL CONTRAST PERFUSION ECHOCARDIOGRAPHY, AT REST OR WITH STRESS, FOR ASSESSMENT OF MYOCARDIAL ISCHEMIA OR VIABILITY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
 0439T ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; UPPER EXTREMITY DISTAL/PERIPHERAL NERVE
 0440T ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; LOWER EXTREMITY DISTAL/PERIPHERAL NERVE
 0441T

0442T ABLATION, PERCUTANEOUS, CRYOABLATION, INCLUDES IMAGING GUIDANCE; NERVE PLEXUS OR OTHER TRUNCAL NERVE (EG, BRACHIAL PLEXUS, PUDENDAL NERVE)

0443T REAL-TIME SPECTRAL ANALYSIS OF PROSTATE TISSUE BY FLUORESCENCE SPECTROSCOPY, INCLUDING IMAGING GUIDANCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0444T INITIAL PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING FITTING, TRAINING, AND INSERTION, UNILATERAL OR BILATERAL

0445T SUBSEQUENT PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING RE-TRAINING, AND REMOVAL OF EXISTING INSERT, UNILATERAL OR BILATERAL

0446T CREATION OF SUBCUTANEOUS POCKET WITH INSERTION OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR, INCLUDING SYSTEM ACTIVATION AND PATIENT TRAINING

0447T REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR FROM SUBCUTANEOUS POCKET VIA INCISION

0448T REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR WITH CREATION OF SUBCUTANEOUS POCKET AT DIFFERENT ANATOMIC SITE AND INSERTION OF NEW IMPLANTABLE SENSOR, INCLUDING SYSTEM ACTIVATION

0449T INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; INITIAL DEVICE

0450T INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; EACH ADDITIONAL DEVICE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0451T INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; COMPLETE SYSTEM (COUNTERPULSATION DEVICE, VASCULAR GRAFT, IMPLANTABLE VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND SUBCUTANEOUS ELECTRODES)

0452T INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL

0453T INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; MECHANO-ELECTRICAL SKIN INTERFACE

0454T INSERTION OR REPLACEMENT OF A PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, ENDOVASCULAR APPROACH, AND PROGRAMMING OF SENSING AND THERAPEUTIC PARAMETERS; SUBCUTANEOUS ELECTRODE

0455T REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; COMPLETE SYSTEM (AORTIC COUNTERPULSATION DEVICE, VASCULAR HEMOSTATIC SEAL, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES)

0456T REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; AORTIC COUNTERPULSATION DEVICE AND VASCULAR HEMOSTATIC SEAL

0457T REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; MECHANO-ELECTRICAL SKIN INTERFACE

0458T REMOVAL OF PERMANENTLY IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM; SUBCUTANEOUS ELECTRODE

0459T RELOCATION OF SKIN POCKET WITH REPLACEMENT OF IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE, MECHANO-ELECTRICAL SKIN INTERFACE AND ELECTRODES

0460T REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; SUBCUTANEOUS ELECTRODE

0461T REPOSITIONING OF PREVIOUSLY IMPLANTED AORTIC COUNTERPULSATION VENTRICULAR ASSIST DEVICE; AORTIC COUNTERPULSATION DEVICE

0462T PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE MECHANO-ELECTRICAL SKIN INTERFACE AND/OR EXTERNAL DRIVER TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, INCLUDING REVIEW AND REPORT, IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, PER DAY

0463T INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER, IMPLANTABLE AORTIC COUNTERPULSATION VENTRICULAR ASSIST SYSTEM, PER DAY

0464T VISUAL EVOKED POTENTIAL, TESTING FOR GLAUCOMA, WITH INTERPRETATION AND REPORT

0465T SUPRACHOROIDAL INJECTION OF A PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)

0466T INSERTION OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO PULSE GENERATOR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

0467T REVISION OR REPLACEMENT OF CHEST WALL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR

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:

- 93050 ARTERIAL PRESSURE WAVEFORM ANALYSIS FOR ASSESSMENT OF CENTRAL ARTERIAL PRESSURES, INCLUDES OBTAINING WAVEFORM(S), DIGITIZATION AND APPLICATION OF NONLINEAR MATHEMATICAL TRANSFORMATIONS TO DETERMINE CENTRAL ARTERIAL PRESSURES AND AUGMENTATION INDEX, WITH INTERPRETATION AND REPORT, UPPER EXTREMITY ARTERY, NON-INVASIVE
- 0126T COMMON CAROTID INTIMA-MEDIA THICKNESS (IMT) STUDY FOR EVALUATION OF ATHEROSCLEROTIC BURDEN OR CORONARY HEART DISEASE RISK FACTOR ASSESSMENT
- 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 COMPUTER-AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFORMED CONCURRENT WITH PRIMARY INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- 0175T COMPUTER-AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFORMED REMOTE FROM PRIMARY INTERPRETATION
- 0208T PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED; AIR ONLY
- 0209T PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED; AIR AND BONE
- 0210T SPEECH AUDIOMETRY THRESHOLD, AUTOMATED;
- 0211T SPEECH AUDIOMETRY THRESHOLD, AUTOMATED; WITH SPEECH RECOGNITION

- 0212T COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (0209T, 0211T COMBINED), AUTOMATED
- MYOCARDIAL STRAIN IMAGING (QUANTITATIVE ASSESSMENT OF MYOCARDIAL MECHANICS USING
- 0399T IMAGE-BASED ANALYSIS OF LOCAL MYOCARDIAL DYNAMICS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
- IMPLANTATION OF NON-BIOLOGIC OR SYNTHETIC IMPLANT (EG, POLYPROPYLENE) FOR FASCIAL
- 0437T REINFORCEMENT OF THE ABDOMINAL WALL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Group 3 Paragraph:

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

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

Group 3 Codes:

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

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: N/A

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 [Back to Top](#)

General Information

Associated Information

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

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

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

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

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

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

This final LCD effective 5/31/2016 combines JFA L34886 in the the JFB L35008 LCD so that both JFA and JFB contract numbers will have the same final MCD LCD number.

Sources of Information

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

Policies from other states:

First Coast Services Option policy

TrailBlazer Health Enterprises, LLC policy

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

Noridian Carrier Advisory Committee Members

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Bibliography

N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		LCD revised for the 2018 HCPCS/CPT updates.	
01/01/2018	R23	<p>Effective 12/31/2017 the following codes will be deleted from Group 1: 0255T, 0293T, 0294T, 0299T, 0300T, 0301T, 0302T, 0303T, 0304T, 0305T, 0306T, 0310T, 0340T, 0438T, 34806, 93982</p> <p>The code description was changed for CPT 32998 from Group 1.</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
10/27/2017	R22	<p>At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included in the LCD are applicable as noted in this policy.</p> <p>This LCD is being revised effective 10/27/2017 to remove CPT code 43210 from Group 1.</p>	<ul style="list-style-type: none"> Reconsideration Request
01/18/2017	R21	<p>10/17/2017 - At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included in the LCD are applicable as noted in this policy.</p> <p>7/26/17 - Category III CPT code 0275T will be removed from the Non-Covered Services LCD due to the Coverage with Evidence Development (CED) clinical trial guidelines found in National Coverage Determination (NCD) 150.13, effective 12/6/16</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
01/18/2017	R20	<p>7/26/17 - At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included in the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> Request for Coverage by a Practitioner (Part B)
01/01/2017	R19	<p>04/18/2017 - Removal of Leadless Pacemaker Category III CPT codes 0387T - 0391T from Group I - effective 1/18/2017</p> <p>Effective 01/01/2017 the description Decision DX UM is removed from Group I description of miscellaneous procedure list.</p> <p>LCD revised for the 2017 HCPCS/CPT codes:</p>	<ul style="list-style-type: none"> Reconsideration Request
01/01/2017	R18	<p>Added to Group I 43284, 43285, 0446T, 0447T, 0448T, 0449T, 0450T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0464T, 0465T, 0466T, 0467T, 0468T.</p> <p>Effective 12/31/2016 the following codes have been deleted:0019T, 0169T, 0286T, 0287T, 0288T, 0289T, 0291T, 0292T, 0392T (replaced with 43284), 0393T (replaced with 43285).</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
08/08/2016	R17	<p>The LCD is revised to remove 86352 from group 1, effective August 8, 2016.</p>	<ul style="list-style-type: none"> Creation of Uniform LCDs Within a MAC Jurisdiction
07/01/2016	R16	<p>The LCD is revised to add the following Category III CPT codes effective 7/1/2016: 0437T, 0438T, 0440T, 0441T, 0442T, 0439T, 0443T, 0444T, 0445T.</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
05/31/2016	R15	<p>Transcranial stimulation for depression listed under Group I for unlisted procedures code descriptions should have been removed when this LCD was revised to remove CPT codes 90867, 90868 and 90869 from Group 1. The effective date of 4/1/2016 remains the same.</p>	<ul style="list-style-type: none"> Typographical Error
05/31/2016	R14	<p>This policy is revised effective 05/31/2016 only to combine JFA L34886 into the JFB LCD so that both JFA and JFB contract numbers will have the same final MCD LCD number.</p>	

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
05/31/2016	R13	This LCD is revised to remove CPT codes 82172 and 83698 from group 1 effective 5/31/2016. Also a correction is made for CPT code 0281T removed from LCD with an effective date of 2/8/2016. The correct effective date should be 2/07/2016 and not 2/8/2016.	<ul style="list-style-type: none"> Other (This policy is revised effective 05/31/2016 only to combine JFA L34886 into the JFB LCD so that both JFA and JFB contract numbers will have the same final MCD LCD number.) Revisions Due To CPT/HCPCS Code Changes
04/01/2016	R12	This LCD is revised to remove CPT codes 90867, 90868 and 90869 from group 1 with an effective date of 4/1/2016.	<ul style="list-style-type: none"> Typographical Error Creation of Uniform LCDs Within a MAC Jurisdiction Reconsideration Request
02/08/2016	R11	The LCD is revised to remove CPT Code 0281T from Group 1 with an effective date of 2/8/2016.	<ul style="list-style-type: none"> NCD Supplementation Reconsideration Request
01/11/2016	R10	<p>The LCD is revised to remove 22856, 22858 and 22861 effective 1/11/2016.</p> <p>The LCD is revised to add the following CPT Codes in Group 1: 43210, 0396T, 0397T, 0398T, 0400T, 0401T, 0402T, 0406T, 0407T, 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0419T, 0420T, 0421T, 0422T, 0423T, 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T.</p> <p>Group 2 - 93050, 0399T</p> <p>Group 3 - 0403T, 0405T. Effective date is 1/1/2016.</p>	<ul style="list-style-type: none"> Reconsideration Request
01/01/2016	R9	<p>93050 added in group 2 to replace 0311T deleted 1/1/2016.</p> <p>Transoral Incisionless Fundoplication is removed from the miscellaneous procedure list. The procedure code is 43210 for 2016 and is added to group 1.</p> <p>The following CPT codes removed from this LCD because they were deleted effective 1/1/2016: 0103T, 0123T, 0223T, 0224T, 0225T, 0233T, 0240T, 0241T, 0243T, 0244T and 0311T.</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
12/01/2015	R8	Medialization Thyroplasty is removed from the policy listed in Group 1 of unlisted procedure code list and should be billed with CPT code 31588 effective December 1, 2015.	<ul style="list-style-type: none"> Reconsideration Request

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/01/2015	R7	The LCD revised to add 0392T and 0393T to Group 1 and to remove CPT code 91112 from group 1.	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
10/01/2015	R6	The CPT Code 0262T was removed from Group 1. Each claim for CPT Code 0262T will be reviewed on a case-by-case basis.	<ul style="list-style-type: none"> Reconsideration Request
10/01/2015	R5	The CPT Code 0262T was removed from Group 1 because the same code was also removed from the ICD9 LCD copy effective 7/9/2015.	<ul style="list-style-type: none"> Reconsideration Request
10/01/2015	R4	<p>Revisions made to the following sections of the policy after the comment period ending 07/11/2014:</p> <ol style="list-style-type: none"> "Coverage Indications, Limitations and/or Medical Necessity" ? 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. ? 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. ? 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. Group 1 - Removed Ova 1 Test, Prolaris® assay for clinical classification of prostate cancer prognosis, 27412, 27415, 27416, 29866, 29867, 29868, 68399. Moved CPT codes 0378T, 0379T and 0380T to group 3. Added 90869 and 0310T. Group 3 - Removed 0199T, Added 0378T, 0379T and 0380T from Group 1. Sources of Information and Basis for Decision - Added #29 to the list. 	<ul style="list-style-type: none"> Creation of Uniform LCDs Within a MAC Jurisdiction Revisions Due To CPT/HCPCS Code Changes
10/01/2015	R3	<p>This LCD is revised to remove Group 4 for Non-covered products: Not Separately Payable as bioengineered skin substitutes for the following HCPCS codes: Q4100, Q4104, Q4105, Q4108, Q4111, Q4112, Q4113, Q4114, Q4115, Q4116, Q4117, Q4118, Q4119, Q4120, Q4122, Q4123, Q4125, Q4126, Q4127, Q4128, Q4129, Q4130, Q4132, Q4133, Q4134, Q4135, Q4136 and Q4147.</p> <p>The LCD was revised due to the Annual CPT code update effective 01/01/2015.</p> <p>The following codes are deleted from the LCD: 0092T, 0181T, 0199T, 0239T and 0334T for Group 1.</p>	<ul style="list-style-type: none"> Other
10/01/2015	R2	<p>The following codes are added to the LCD: 0357T, 0375T, 0376T, 0378T, 0379T, 0380T, 0381T, 0382T, 0383T, 0384T, 0385T, 0386T, 0387T, 0388T, 0389T, 0390T, 0391T, 22858, 92145 (replaced 0181T), and 93702 (replaced 0239T).</p> <p>0126T is moved from Group 1 to Group 2. Q4147 is moved from Group 2 to Group 4.</p> <p>07/01/2014 - Codes 0347T, 0348T, 0349T, 0350T, 0351T, 0352T, 0353T, 0354T, 0355T, 0356T, 0358T, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0373T, 0374T were added to the non-covered list per the new Category III CPT codes issued in the January release. 68399 and 0336T were removed. Q4147 was added to Group 2 paragraph codes, not separately payable.</p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes
10/01/2015	R1	<p>03/01/2014 Prolonged Extracorporeal percutaneous transseptal assist device, codes 0075T and 0076T removed.</p>	<ul style="list-style-type: none"> Provider Education/Guidance

[Associated Documents](#)

Attachments N/A

Related Local Coverage Documents Article(s) [A55681 - Additional Information Required for Coverage and Pricing for Category III CPT® Codes](#)

Related National Coverage Documents N/A

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- Not proven effective
- Investigational
- Experimental
- Not medically necessary
- Statutorily Non-covered
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