MEDICAL MUTUAL®

Medical Policy

Policy:	**202407**	**Effective Date:**	**05/12/2026**
SUBJECT:	**Not Standard of Care**	**Annual Review Date:**	**09/30/2025**
		Last Revised Date:	**04/24/2026**

SERVICES IN THIS LIST OF CORPORATE MEDICAL POLICIES ARE CONSIDERED NOT STANDARD OF CARE

Definition: Not standard of care describes a drug, medical device, treatment, or procedure that is considered not appropriate regarding standards of good medical practice, is used primarily for purposes of convenience, or may be considered an inappropriate level of service that can be safely provided.

When determining a status of not standard of care, the Company considers information from multiple sources, including but not limited to published, peer-reviewed literature; clinical practice guidelines published by consortia of medical organizations; commercial health technology assessment organizations such as Hayes, a symplr Offering; position statements from specialty and sub-specialty societies; and UpToDate. Please see the Healthcare Technology Assessment Program Description for more details: **https://www.medmutual.com/-/media/908301A8044D420BB377375914643593.ashx**.

This Corporate Medical Policy applies to commercial lines of business as well as Medicare Advantage when there is no National Coverage Determination, Local Coverage Determination, or other guidance published by the Centers for Medicare & Medicaid Services.

Medical Necessity: Based upon our findings, the Company has determined that the following services have not been accepted in the medical community as the standard or appropriate means of treatment for these conditions. The Company considers the following services as indicated by the Applicable Code(s) or other related code(s) not listed here **not standard of care and not** eligible for reimbursement.

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
200211	Breast Cancer Screening and Diagnostic Procedures (Breast Ductal Lavage and	Breast ductal lavage,-fiberoptic ductoscopy, mammory ductoscopy, and breast duct endoscopy (i.e Acueity System, Acueity, Inc., Larkspur, CA) are utilized to evaluate individuals at high risk for breast cancer. These procedures are intended to be used in conjunction	CPT 19499† †When *unlisted procedure, breast* (19499) is determined to be breast ductal lavage or fiberoptic ductoscopy.	09/09/2025

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	Fiberoptic Ductoscopy)	with routine clinical breast examination and mammography for early detection and histopathologic diagnosis of nonpalpable breast cancers. Breast ductal lavage is a technique in which epithelial cells (nipple aspirate fluid) are collected from the breast ductal system for cytological analysis. Mild suction is applied to the nipple to identify fluid-yielding duct(s). A microcatheter is then advanced through a duct orifice into the duct(s) and a saline solution is introduced. Saline and cellular material are withdrawn through the catheter and collected in a syringe for cytologic examination. Ductal fluid is analyzed to detect cytological abnormalities suggestive of breast cancer. Fiberoptic ductoscopy is performed by inserting a fiberoptic microendoscope into a ductal orifice and advancing the scope under direct visualization. Abnormal intraductal areas are either biopsied or marked for image-guided core biopsy.		
200520	Urinary Incontinence and Overactive Bladder Treatments	There are many types of devices, supplies and procedures targeted at treating urinary incontinence and overactive bladder. Extracorporeal magnetic stimulation is pulsed magnetic stimulation of sacral and/or pudendal nerves to facilitate contractions of pelvic floor muscles. Therapy is intended to strengthen pelvic floor musculature, thus reducing urinary incontinence. In addition, numerous Kegel exercise	CPT 53899† HCPCS Codes E0715, E0716 †When unlisted procedure, urinary system – is determined to be extracorporeal magnetic stimulation for urinary incontinence.	08/12/2025

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		assistance devices are available without a prescription and over the counter (e.g., Flyte). The goal of these devices is to guide the user through pelvic floor muscle contractions with vibrations and/or electrical prompting.		
200522	Percutaneous or Endoscopic Epidural Adhesiolysis - Chronic Low Back Pain	Epidural adhesiolysis (epidural neuroplasty) is a minimally invasive surgical procedure performed percutaneously or by spinal endoscopy for treatment of chronic post-surgical back pain unresponsive to conventional medical therapy. Percutaneous epidural adhesiolysis (percutaneous adhesiolysis, percutaneous lysis of epidural adhesions) involves inserting a needle into the epidural space at the spinal level where fibrosis, scar tissue or adhesions are suspected. Disruption of adhesions believed to be responsible for symptoms is attempted by introducing a catheter through the needle and injecting various solutions (e.g., hypertonic saline, enzyme, steroid, anesthetic) or by mechanical manipulation of the catheter. Endoscopic epidural adhesiolysis (epiduroscopy, spinal endoscopy with epidural adhesiolysis) is similar to the percutaneous technique with the added theoretical advantage of directly visualizing the epidural space while disrupting adhesions and delivering injected drugs to target areas. The procedure is performed following failure of percutaneous epidural adhesiolysis.	CPT 62263, 62264, and 64999† †When unlisted procedure, nervous system (CPT Code 64999) – is determined to be a Percutaneous or Endoscopic Epidural Adhesiolysis	10/14/2025

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201022	Spinal Unloading Device (Lumbar)	A spinal unloading device is intended as a conservative treatment for subacute and chronic low-back pain or scoliosis and can be patient- or therapist-operated. Patient-operated devices provide a traction-effect by shifting weight from the lower back onto the hips, whereas therapist-operated devices apply distracting forces to the spine. Patient-operated devices include, but are not limited to, Orthotrac Pneumatic Vest (Orthofix Inc.) and LTX 3000 (Spinal Designs International Inc.)	HCPCS E0830†, E1399†, and L1499† †When ambulatory traction device, all types, each (E0830), durable medical equipment, miscellaneous (E1399), or spinal orthosis, not otherwise specified (L1499) is determined to be spinal unloading device (lumbar).	02/10/2026
201105	Prolotherapy	Prolotherapy for musculoskeletal conditions involves the injection of sclerosing solutions into or around joints, muscles, or ligaments. Solutions, such as dextrose-glycerine-phenol, Sarapin® (High Chemical Company, Levittown, PA), sodium morrhuate, psyllium seed oil, and zinc sulfate are used to induce an inflammatory reaction, spurring new fibrous tissue growth. This approach aims to stabilize injured joints and ligaments, thereby reducing chronic musculoskeletal pain.	HCPCS M0076	08/01/2025
201324	Thermography	Thermography (temperature gradient studies) is a non-invasive imaging technique designed to measure and display infrared or heat energy emanating from the skin surface. This technique is reported to demonstrate temperature differences that may be due to altered blood flow across various organs and tissues and is intended to	CPT 93740, 76499† ICD-10-PCS Procedure Code 4A0.ZXKZ †When unlisted diagnostic radiographic procedure	07/03/2025

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		assist in the diagnosis of numerous diseases.	(76499) is determined to be thermography.	
201535	Noninvasive Rupture of Membranes Testing in Pregnancy	The fetal membranes protect the developing fetus during pregnancy. Tearing or rupture of the membranes (ROM) can occur normally during labor, but when this occurs prior to 37 weeks of gestation it is considered premature ROM (PROM). Noninvasive tests have been developed to assess suspected PROM. These assays detect the presence of specific placental proteins in vaginal fluid that are only present when the membrane is ruptured. The test is intended to aid in the detection of ROM in pregnant women with signs, symptoms or complaints suggestive of premature rupture. In most cases PROM can be diagnosed based on the patient's history and physical examination.	CPT 84112	08/12/2025
201537	Radiofrequency Treatment for Pain -Radiofrequency ablation for sacroiliac joint -Radiofrequency ablation of genicular nerve -Radiofrequency ablation for complex regional	Radiofrequency treatment involves the use of an electrical current produced by a radio wave to heat a small area of nerve tissue. The heat from the radio wave is then thought to decrease pain signals from the specific area of treatment. Pulsed radiofrequency (cold radiofrequency, pulsed radiofrequency ablation) is a type of radiofrequency treatment during which a generator delivers bursts of radiofrequency current to specific nerves. Targeted nerves are not destroyed and the mechanism of action is not well understood.	CPT 64624, 64625, 64640†, 64999† †When destruction by neurolytic agent, other peripheral nerve or branch (64640), or unlisted procedure, nervous system (64999) is determined to be radiofrequency treatment for pain as described in this policy.	06/09/2026

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	pain syndrome (CRPS) -Pulsed Radiofrequency for Chronic Pain			
201621	Pneumatic Compression Device - Pneumatic Compression of Trunk and Chest	A pneumatic compression device consists of an air inflatable garment and an electrical pump that intermittently compresses the affected area. The device is intended to reduce abnormal fluid accumulation associated with lymphedema, chronic venous insufficiency with venous stasis ulcer(s) and arterial insufficiency.	HCPCS Codes E0656, E0657, E0658 and E0659	11/11/2025
201709	Transanal Radiofrequency Therapy for Fecal Incontinence	Transanal radiofrequency therapy (Secca®, Mederi Therapeutics, Inc., Greenwich, CT) has been reported as a minimally invasive treatment for fecal incontinence when conventional treatment has failed. Radiofrequency energy is delivered to the anal canal sphincter muscle complex, producing thermal-induced local injury. As tissue healing occurs over several months, anal canal tone is reported to increase with resultant decreased fecal incontinence.	CPT 46999† †When unlisted procedure, anus (46999) is determined to be transanal radiofrequency therapy for fecal incontinence.	10/14/2025
2019-C	REGENETEN Bioinductive Implant	REGENETEN Bioinductive Implant is a graft derived from bovine Achilles tendon that supports the formation of new tendinous tissue for treatment of rotator cuff disease. The patch is surgically inserted and absorbs within roughly 6 months leaving a layer of new tendinous tissue to augment the existing	CPT Code 29827† HCPCS code C1713†, C1763† †Considered investigational, not standard of care and not eligible for reimbursement when Arthroscopy, Shoulder; with rotator cuff repair (CPT	10/14/2025

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		tendon while disrupting disease progression.	29827), Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) (HCPCS C1713) or Connective Tissue, Non/Human (includes Synthetic (HCPCS C1763) is determined to be REGENETEN Bioinductive Implant.	
2019-D	Computer Assisted Musculoskeletal Surgical Navigation System	Computer assisted musculoskeletal surgical navigation system refers to a computer tracking system that assists with preparation and alignment during surgical procedures. Computer assisted navigation can be image-based or non-image based.	CPT 20985, 0054T, 0055T	02/10/2026
201942	Bulking Agents for Fecal Incontinence - Solesta®	Solesta® (Oceana Therapeutics, Inc., Edison, NJ) is a biocompatible bulking agent administered by submucosal trans-anal injection. Solesta® may enhance perianal tissue bulking, resulting in narrowing of the anal opening and improved muscle control, thereby reducing involuntary loss of feces. Solesta® is intended for individuals 18 years and older who have failed conventional therapy for fecal incontinence.	CPT 46999† HCPCS L8605 †When unlisted procedure – anus (46999) is determined to be injection of bulking agents for fecal incontinence (Solesta®)	01/13/2026
202603	Platelet-Rich Plasma	Platelet-rich plasma (PRP; also referred to as autologous platelet concentrate or autologous platelet gel) is a preparation of concentrated autologous human platelets suspended in a small volume of plasma. Platelets contain numerous biologically active growth factors that may play a role in wound and soft tissue repair (e.g., ligaments and tendons) as	CPT Codes 0232T and 69620† HCPCS G0460, G0465, P9020 †When *myringoplasty* (69620) is determined to be autologous platelet-rich plasma.	05/12/2026

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		well as in stimulating new bone formation. PRP has been promoted for the treatment of chronic, nonhealing wounds, such as chronic venous ulcers and diabetic foot ulcers, as well as for ligament and tendon injuries, including epicondylitis and tendinopathies. PRP has also been promoted for adjunctive use with bone grafts during orthopedic, oral, and maxillofacial surgical procedures, with the proposed intent of enhancing bone healing and regeneration.		
	InterQual® CP:Durable Medical Equipment Continuous Passive Motion Device (CPM), Knee InterQual® CP:Durable Medical Equipment Continuous Passive Motion Device (CPM), Upper Extremity	Continuous passive motion (CPM) devices provide continuous passive mobilization of a joint in the immediate post-operative period. CPM devices aim to maintain, restore, or increase joint range of motion by mechanically inducing passive movement of the joint, thereby improving mobility as an adjunct to conventional physiotherapy.	HCPCS Codes E0935, E0936	

Documentation Requirements

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary,

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investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

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Sources of Information:

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