MEDICAL MUTUAL®

Medical Policy

Policy:	**202406**	**Effective Date:**	**05/12/2026**
SUBJECT:	**Investigational/Experimental Procedures/Devices/Services**	**Annual Review Date:**	**09/23/2025**
		Last Revised Date:	**04/24/2026**

SERVICES IN THIS LIST OF CORPORATE MEDICAL POLICIES ARE CONSIDERED INVESTIGATIONAL/EXPERIMENTAL

Definition: Investigational/experimental describes a drug, medical device, treatment, or procedure that meets any of the following conditions:

- A drug or medical device cannot be lawfully marketed without clearance or approval of the U.S. Food and Drug Administration, and clearance or approval for marketing has not been given at the time the drug or device is furnished.
- Reliable evidence shows that the drug, medical device, treatment, or procedure is not considered the standard of care, is the subject of an on-going phase I, II or III clinical trial, or is under study to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.
- The consensus of opinion among experts regarding the drug, medical device, treatment, or procedure is that further studies or clinical trials are required to determine its maximum tolerated dose, toxicity, safety, or efficacy, as compared with the standard means of treatment or diagnosis.

When determining a status of investigational/experimental, 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**.

The American Medical Association (AMA) develops and maintains a set of temporary codes to track the utilization of emerging technologies, services, and procedures that are referenced as CPT Category III codes. The Category III code description does not establish a service or procedure as safe, effective, or applicable to the clinical practice of medicine. The AMA indicates that a Category III code will typically be archived within 5 years, and the description is either converted to a specific Category I code or should be reported with a Category I unlisted code.

PLEASE NOTE: The Company considers Category III codes to be investigational/experimental except when explicitly covered by a corporate medical policy (or national or local coverage determination when appropriate).

MEDICAL MUTUAL®

Medical Policy

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 demonstrated equivalence or superiority to currently accepted standard means of treatment or standard diagnostic technique. The Company considers the following services as indicated by the Applicable Code(s) or other related code(s) not listed here **investigational** and **not** eligible for reimbursement:

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
200139	Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions	Extracorporeal shock wave therapy (ESWT) is a noninvasive technique that directs low or high energy pulses to a specific painful tissue area. These pulses aim to break down calcium deposits, decrease scar tissue, and reduce inflammation, thereby decreasing pain and promoting healing at the affected site. Musculoskeletal conditions may include (but are not limited to) plantar fasciitis, shoulder tendonitis, Achilles' tendinopathy, and lateral epicondylitis.	CPT Codes 28890, Category III 0101T, 0102T, 0512T, 0513T	02/10/2026
200224	Sublingual Immunotherapy	Sublingual immunotherapy (SLIT) is a form of allergy treatment that utilizes repeated, sublingual placement of diluted allergen extract drops as an allergen delivery system. Gradually increased doses of the allergen are administered to achieve tolerance to the allergy-causing substance. Theoretical advantages include a lower risk of serious side effects and better patient acceptance.	CPT Code 95199† †When *unlisted allergy/clinical immunologic service or procedure* (95199) is determined to be sublingual (allergy) immunotherapy. NOTE: Odactra, Grastek, Ragwitek, or Oralair may be covered, please see Drug Policy **Sublingual Allergen Extract**	01/13/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
			Immunotherapy for more information.	
2003-C	Electrical Stimulation for Treatment of Dysphagia	Transcutaneous electrical stimulation (neuromuscular electrostimulation; transcutaneous electrical stimulation) of muscles coordinating swallowing is a noninvasive therapy reported to be utilized for treatment of oropharyngeal dysphagia. A hand-held electrical stimulator (e.g., VitalStim) is connected to a pair of external electrodes positioned to deliver electric current to swallowing muscles of the neck. The device provides external electrical stimulation to pharyngeal swallowing musculature in an attempt to strengthen neuromuscular pathways involved in the swallow reflex.	CPT Codes 97014, 97032 and 97039† HCPCS Code E0745 †When unlisted modality (specify type and time if constant attendance) (97039) is determined to be electrical stimulation for treatment of dysphagia.	11/11/2025
200310	Gastroesophageal Reflux Disease: Endoscopic and Laparoscopic Therapies	Gastroesophageal reflux disease (GERD) is the chronic abnormal reflux of gastric contents into the esophagus, resulting in symptoms of heartburn and/or regurgitation. This gastric reflux may at times result in mucosal injury with esophagitis or other complications. Endoscopic and laparoscopic therapies have been developed to treat GERD; these approaches alter the gastroesophageal junction structure in order to diminish proximal migration of gastric contents and decrease reflux and regurgitation	CPT 43201, 43210, 43236, 43257, 43284, 43289, 43499† and 43999† †When unlisted procedure, esophagus (43499) or unlisted procedure, stomach (43999) is determined to be endoscopic plication/suturing for treatment of gastroesophageal reflux disease.	01/13/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE

		symptoms, thereby resolving esophagitis.
		
		Endoscopic and laparoscopic therapies may be classified into four basic categories as outlined below, with examples (NOTE: this list is not all-inclusive):
		
		• Radiofrequency energy:
		  o Stretta®
		• Endoscopic plication/suturing
		  o Medigus Ultrasonic Surgery Endostapler (MUSE)
		  o Bard® Endoscopic Suturing System (BESS)
		  o Apollo OverStitch endoscopic suturing system
		  o Endoscopic Plicator System (NDO Surgical)
		  o Syntheon ARD Plicator
		  o Transoral Incisionless Fundoplication (TIF) with EsophyX (EndoGastric Solutions Inc.)
		  o StomaphyX
		  o C-BLART (clip band ligation anti-reflux therapy)
		• Polymer injection
		  o Ethylene-vinyl alcohol co-polymer (Enteryx®)
		  o Hydrogel prosthesis (Gatekeeper™ Reflux Repair System)		

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		○ Plexiglas polymethylmethacrylate (PMMA) microspheres (Arkema Inc., Bristol, PA) ○ Angelchik anti-reflux prosthesis • Laparoscopic magnetic sphincter augmentation ○ LINX device (LINXTM Reflux Management System)		
2005-J	Vertebral Axial Decompression Devices	Vertebral axial decompression devices (e.g., VAX-D®, Accu-SPINA System, etc.) are computer-controlled tables that apply distractive tension along the spinal column. These devices are promoted as non-invasive, non-surgical procedures that treat low back pain due to conditions such as lumbar disc herniation, degenerative disc disease, posterior facet syndrome, sciatica, or radiculopathy.	HCPCS S9090	08/12/2025
2006-G	Fluid-Ventilated Gas-Permeable Scleral Lenses	Fluid-ventilated, gas-permeable scleral lenses (e.g., BostonSight PROSE device) are utilized for management of irregular corneal astigmatism that is unable to be corrected with traditional contact lenses or for treatment of diseases of the corneal surface. These devices can be custom-fitted and sized to rest largely on the surrounding sclera, creating a fluid-filled space	CPT 92499 HCPCS S0515	11/11/2025

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		overlying the cornea, which optically neutralizes corneal surface irregularities. The fluid-filled space protects the corneal surface from atmospheric desiccation, reduces the intensity of ocular pain and may facilitate healing of persistent epithelial defects.		
2009-C	Anal Fistula Plug	An anal fistula plug (e.g., Biodesign® [Surgisis®] Anal Fistula Plug) is a freeze-dried bioabsorbable xenograft formulated from porcine small intestinal submucosa, which is intended as a minimally invasive treatment for anorectal or rectovaginal fistulas.	CPT 46707	08/12/2025
2011-C	Wireless Gastrointestinal Motility Monitoring System -Suspected Gastric Motility Disorders	Wireless gastrointestinal motility monitoring systems (e.g., SmartPill® GI Monitoring System) have been proposed as an alternative testing method for evaluation of suspected gastrointestinal motility disorders (e.g., gastroparesis). The system senses and records temperature, pH, and pressure measurements via sensors contained within an ingestible capsule as it travels through the gastrointestinal tract. Measurements are transmitted from the capsule via a radiofrequency signal to an external data receiver and subsequently downloaded to a personal computer for analysis and review by a physician.	CPT Code 91112	04/14/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
2013-C	Investigational Treatments for Tendon and Soft Tissue Injuries	Several investigational procedures exist that are purported to treat pain and injury in various tendons and other soft tissues. One of these is the Tenex percutaneous ultrasonic tenotomy system. The procedure involves percutaneous insertion of the TX1 MicroTip™ through an incision near a tendon or soft tissue injury site (i.e., lateral or medial epicondyle, patellar tendon, rotator cuff, plantar fascia or Achilles tendon) under ultrasonic guidance. The probe ultrasonically emulsifies and removes tendon scar tissue. The Tenjet System is another treatment modality intended to reduce pain and injury in tendons and soft tissues. The system utilizes a needle to deliver high-velocity saline that resects diseased tissue and removes it.	CPT Code 20999†, 23929†, 24999†, 27599†, 27899† and 28899† †When unlisted procedure-musculoskeletal system, general (20999), unlisted procedure, shoulder (23929), unlisted procedure, humerus or elbow (24999), unlisted procedure, femur or knee (27599), unlisted procedure, leg or ankle (27899) or unlisted procedure, foot or toes (28899) is determined to be the Tenex Percutaneous Ultrasonic Tenotomy System or the Tenjet System. Note: if a tenotomy or fasciotomy code is used to bill for Tenex or Tenjet Systems, the procedure will be denied as investigational and experimental.	12/09/2025
2014-A	Non-Surgical Treatments for Obstructive Sleep Apnea • Oral pressure therapy devices • Electrical stimulation of the tongue devices • Devices for positional	Many non-surgical treatments are available for obstructive sleep apnea. Oral pressure therapy (e.g., Attune Sleep Apnea System, iNAP One Sleep Therapy System, Winx Sleep Therapy System) involves the use of an intraoral negative pressure gradient device intended to improve airflow by increasing airway size for	HCPCS A7002†, A7047†, E0600†, E0490, E0491, E0492, E0493, E0530 †When tubing used with suction pump, each (A7002) or oral interface used with respiratory suction pump, each (A7047) or respiratory suction pump, home model, portable or stationary, electric	11/11/2025

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
	obstructive sleep apnea	the treatment of obstructive sleep apnea. Daytime neuromuscular electrical stimulation therapy is another treatment option that uses a device (e.g. eXciteOSA) to deliver electrical stimulation through a mouthpiece that is placed around the tongue. The stimulation is thought to improve tongue muscle tone and endurance to prevent upper airway collapse and obstructive sleep apnea during the night. Devices for treatment of positional obstructive sleep apnea (POSA) can be worn around the neck or chest promting the user with soft vibrations to shift to a nonsupine position (e.g. Night Shift).	(E0600) is determined to be oral pressure therapy for treatment of obstructive sleep apnea.	
2016-B	Myoelectric Orthotic Devices- Upper Extremity	Myoelectric orthotic mobility systems (e.g., MyoPro®, Myomo e100, IpsiHand) are designed to provide limb and joint support as well as powered range of motion. These systems are intended to compensate for muscle weakness and disability resulting from cerebrovascular disease, neuromuscular disorders and injuries. Myoelectric orthotic mobility systems may help weak or paralyzed individuals to regain function and perform activities of daily living.	HCPCS A9300†, E0738, E0739, E1399†, L3904, L3999†, L7499†, L8701, and L8702 †When exercise equipment (A9300), durable medical equipment, miscellaneous (E1399), upper limb orthosis, not otherwise specified (L3999); or upper extremity prosthesis, not otherwise	05/12/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		NOTE: The Company considers myoelectric prosthesis medically necessary when criteria are met in InterQual® CP:Procedures Prosthetics, Myoelectric, Upper Extremity.	specified (L7499) is determined to be myoelectric upper limb orthotic devices	
2018-C	Actigraphy as a Standalone Procedure	Actigraphy involves monitoring motor activity with a portable device over an extended period of time. Devices include a small accelerometer that is typically worn on the wrist to record movement during sleep and may be used in a facility-based laboratory or in the home setting. Actigraphy has been proposed as a useful technique in combination with, or in place of, polysomnography to detect sleep disorders such as obstructive sleep apnea.	CPT Code 95803	04/14/2026
2019-A	Wireless Pulmonary Artery Pressure Monitoring Devices and Accessories	The CardioMEMS HF System (Abbott) is intended to wirelessly monitor pulmonary artery pressure and heart rate in New York Heart Association Class II or III heart failure patients who either have been hospitalized for heart failure in the previous year and/or have elevated natriuretic peptides. The CorPASS (Endotronix) is intended to wirelessly monitor NYHA Class III heart failure patients who are at home on diuretics and guideline-directed medical therapy (GDMT) as well as have been stable for 30 days on GDMT.	CPT Codes 33289, 93264 HCPCS Codes C2624, G0555	01/13/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
2019-B	Subchondroplasty® (SCP®) with AccuFill® Bone Substitute Material (BSM)	The Subchondroplasty® Procedure (SCP®) is a minimally invasive, fluoroscopically assisted procedure in which subchondral bone defects are filled with AccuFill® Bone Substitute Material (BSM), a calcium phosphate compound. Inside the subchondral defects AccuFill forms a hard, nanocrystalline scaffold that is replaced with new bone over time. This procedure is typically performed arthroscopically.	CPT Codes 0707T, 0869T, 29855†, 29856†, 29892† †When arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar (29855), arthroscopically aided treatment of tibial fracture, proximal (plateau); bicondylar (29856), or arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture (29892), or any other code is determined to be Subchondroplasty® (SCP®) with AccuFill® Bone Substitute Material (BSM); this includes but is not limited to hips and knees. NOTE: This list of applicable codes is not all-inclusive. The Company reserves the right to apply this policy to the procedure performed regardless of how the procedure was coded by the provider.	02/10/2026
2019-F	Allogeneic, xenographic, synthetic, and composite nerve grafts and conduits	Peripheral nerve injuries or defects may compromise sensory and/or motor function and can profoundly impact quality of life as well as autonomy. Autologous nerve transplantation is the standard surgical treatment but has significant limitations, such as a need for a secondary surgery and an associated	CPT Codes 64910, 64912, 64913, 64999† HCPCS Codes C9352, C9353, C9355, C9361 †When unlisted procedure, nervous system (CPT 64999) is determined to be	04/14/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		risk for surgical donor site morbidity. Nerve allografts comprise another approach, but some allogeneic nerve transplants may require concurrent immunosuppression. Tissue-engineered, decellularized nerve grafts and nerve conduits, as well as grafts and conduits from other sources, are intended to treat peripheral nerve injuries or defects while minimizing the potential for adverse events that are common to current treatments.	allogeneic, xenographic, synthetic, or composite nerve grafts and/or conduits.	
2019-G	Investigational Spinal Procedures • Minimally invasive spinal fusion approaches using only indirect visualization (e.g. endoscopic fusion) • Spinal fusion with a pre-sacral interbody approach (e.g. AxiaLIF) • Percutaneous Endoscopic Lumbar Discectomy (PELD) • Endoscopic Disc Decompression • Laser Disc Decompression • Minimally Invasive Lumbar	There are many investigational spinal procedures that lack the clinical evidence for efficacy compared to other more standard procedures. Many of these include minimally invasive procedures for spinal fusion, discectomy and disc decompression. They are intended to increase stability of vertebral bones and joints and/or relieve any pressure being applied to the nerves and to thus alleviate chronic numbness, stiffness, and pain of the back. NOTE: Minimally invasive spinal fusion approaches such as XLIF and DLIF, when performed with direct visualization, are approvable based on InterQual® CP:Procedures Fusion, Lumbar Spine.	CPT 22586, 27278, 62287†, 62380†, 63020†, 63030†, 63035†, and 64999† Category III 0274T and 0275T HCPCS C1821, S2348 †When aspiration of nucleus pulposus of intervertebral disk, lumbar (62287), laminotomy/decompression nerve root(s); one interspace/cervical (63020), endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial	05/12/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
	Decompression (mild®)* • Nucleoplasty Disc Decompression • LinQ sacroiliac joint stabilization system *Approval for mild® may be permitted for a Medicare Advantage member if they are enrolled in an approved clinical study that meets criteria put forth by the Centers for Medicare & Medicaid Services (CMS). This information may be available through the CMS website.	See also InterQual® CP:Procedures Interspinous Process Device with or without Open Decompression.	facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar (62380), laminotomy/decompression nerve root(s); one interspace, lumbar (63030); laminotomy with decompression of nerve root(s);each addl. (63035); or unlisted procedure, nervous system (64999) is determined to be minimally-invasive disc decompression procedures.	
202009	Dry Needling	Dry needling, also known as intramuscular stimulation, involves the use of solid 'noninjection' needles which are used to penetrate the skin and stimulate specific triggerpoints, muscles and connective tissue. Dry needling is intended to reduce pain and improve range of motion, however more studies are needed to demonstrate its safety and effectiveness.	CPT Codes 20560, 20561	05/21/2025
202011	Microsurgical Treatments for Lymphedema –	Lymphedema refers to the accumulation of fluid in tissues with inadequate lymphatic drainage,	CPT Codes 1019T, 15756†, 35206†, 35226†, 35236†,	04/14/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
	Lymphatic Bypass Procedures	which often results from breast cancer surgery, mastectomy, or radiation treatments. Microsurgical treatments for lymphedema aim to increase the capacity of the lymphatic system by creating new channels for lymphatic fluid to travel. There are several methods of lymphatic bypass, including (but not limited to) lymphovenous bypass, lymphaticovenular anastomosis, lympholymphatic anastomosis, and lymphatic-capsular-venous anastomosis.	35266†, 37799†, 38308†, 38790†, 38999†, 49906†, 76499† †When free muscle or myocutaneous flap with microvascular anastomosis (15756), repair blood vessel, direct; upper extremity (35206), repair blood vessel, direct; lower extremity (35226), repair blood vessel with vein graft; upper extremity (35236), repair blood vessel with graft other than vein; upper extremity (36266), unlisted procedure, vascular surgery (37799), lymphangiotomy or other operations on lymphatic channels (38308), unlisted procedure, hemic or lymphatic system (38999), free omental flap with microvascular anastomosis (49906), or unlisted diagnostic radiographic procedure (76499) is determined to be microsurgical treatments for lymphedema.	
202015	Irreversible Electroporation (IRE)	Irreversible electroporation (IRE) is a nonthermal ablative technique that induces cell death by directly delivering multiple pulses of high-voltage electrical current to a targeted area. The electrical current permanently changes cell permeability by causing tiny holes to open in the cell membrane. This technique preferentially impacts cells, thereby causing less damage to surrounding tissues than with thermal ablative techniques	CPT Codes 0600T, 0601T, 47399† ICD 10 Procedure Codes 0F500ZF-0F504ZF, 0F510ZF-0F514ZF, 0F520ZF-0F524ZF, 0F5G0ZF-0F5G4ZF †When unlisted procedure, liver (47399) is determined to be irreversible electroporation	09/09/2025

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
202016	Cryotherapy or radiofrequency therapy ablation for Allergic and Non-Allergic Rhinitis (ClariFix and RhinAer)	Cryoablation involves the use of extreme cold to destroy tissue. The ClariFix device is a hand-held, disposable device used to destroy tissue during surgical procedures, including in adults with chronic allergic and non-allergic rhinitis. Radiofrequency ablation involves the use of heat generated by radiofrequency waves to destroy tissue. RhinAer uses low temperature energy to ablate the nerve that causes chronic allergic and non-allergic rhinitis.	CPT Codes 31242, 31243	09/09/2025
202202	Peripheral Electrical Stimulation to Reduce Tremor (e.g. Cala Trio)	Cala Trio is a devise worn on the wrist that provides non-invasive electrical stimulation to the median and radial nerves. This type of stimulation therapy is called transcutaneous afferent patterned stimulation (TAPS) and is intended to reduce tremor in the targeted arm.	HCPCS Codes A4542, E0734	09/09/2025
202203	Non-Pneumatic Compression Devices	Non-pneumatic compression devices (e.g., Koya Dayspring System) are wearable systems that provide sequential gradient compression for the treatment and management of lymphedema. These devices are intended to promote lymph flow while allowing patients to maintain mobility during treatment.	HCPCS Codes E0677, E0678, E0679, E0680, E0681, E0682, E0683	08/12/2025
202204	Intravascular Lithotripsy (IVL)	Intravascular lithotripsy (IVL) is a procedure used to open narrow or blocked coronary or peripheral arteries due to calcification prior to stent implantation. The procedure is	CPT Code 92972 HCPCS Codes C9764, C9765, C9766, C9767,	01/13/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		administered with a device (e.g. Shockwave Intravascular Lithotripsy System) that consists of a catheter which delivers localized pressure waves to the lesion. These pressure waves are intended to break up the calcification that is restricting blood flow.	C9772, C9773, C9774, C9775, C1761	
202205	Cardiac Contractility Modulation Therapy	Cardiac Contractility Modulation (CCM) therapy (e.g. Optimizer Smart System, Impulse Dynamics) is a proposed treatment for heart failure in patients who are not eligible for cardiac resynchronization therapy. It involves the implantation of a pulse generator into the right pectoral region of the heart. The generator then delivers CCM signals, which are biphasic and relatively high voltage, to the right ventricular septum which is thought to increase the contractile strength of cardiac muscle.	CPT Codes 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0915T, 0916T, 0917T, 0918T, 0919T, 0920T, 0921T, 0922T, 0923T, 0924T, 0925T, 0926T, 0927T, 0928T, 0929T, 0930T, 0931T, 0948T, 0949T HCPCS Code K1030	01/13/2026
202304	Subacromial Spacer	Subacromial- balloon spacer (InSpace – Stryker) is a biodegradable implant designed to restore the subacromial space in rotator cuff injury. This is reported to be a less invasive solution compared to other surgical treatment options that require fixation devices or grafts in the presence of rotator cuff injury, includes debridement (e.g., limited, or extensive), subacromial decompression,	HCPCS Code C9781	01/13/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		acromioplasty, and biceps tenodesis when performed.		
202501	Medial Knee Implanted Shock Absorber (MISHA Knee System)	The MISHA Knee System (Moximed Inc.) is an implantable shock absorber that is intended to treat knee osteoarthritis. The MISHA consists of an implant that is placed outside of the knee joint, where it is connected to the proximal tibia and distal femur. The implant is designed to offload the medial knee joint while supporting natural movement.	CPT Code 27599† HCPCS Codes C1776†, C8003† †When 27599 (unlisted procedure, femur or knee), C1776 (joint device (implantable)), or C8003 (implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (e.g., fluoroscopy)) is found to be medial knee implanted shock absorber.	01/13/2026
202602	Bioimpedance Spectroscopy	Bioimpedance spectroscopy (BIS) is a noninvasive technique utilized in the measurement of extracellular fluid volume differences between the arms and has been reported to aid in detection of unilateral arm lymphedema in women. A small electrical current is passed through electrodes attached to the wrists to measure resistance (impedance) to current. A device is utilized to record impedance at varying frequencies. Results are analyzed to determine if more fluid exists as compared to the contralateral limb. This technique has been proposed as an alternative to circumferential measurements and water immersion methods to indicate trends toward the potential development of lymphedema.	CPT Codes 0358T, 93702	05/12/2026

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
	InterQual® CP:Procedures Interspinous Process Device with or without Open Decompression	Interspinous distraction devices, such as the Wallis, X-Stop, Coflex, DIAM, Aperius, and Superion devices, are spacers placed between vertebral levels to limit extension without affecting flexion, axial rotation, or lateral bending. They reduce intradiskal pressure and facet load, and they prevent narrowing of the spinal canal and neural foramen. Proposed applications include relief of discogenic low back pain and neurogenic claudication due to spinal stenosis.	CPT Codes 22867, 22868, 22869, 22870 HCPCS: C1821	
	InterQual® CP:Durable Medical Equipment Trigeminal and Vagus Nerve Stimulator Devices, Noninvasive	A transcutaneous vagus nerve stimulator is a portable, battery-powered device that is either placed directly on the skin of the neck or connected to an electrode that is placed in the left ear. Preprogrammed, intermittent electrical pulses are transmitted to the brain via the various branches of the vagus nerve.	HCPCS Codes E0735 and E1399† †When *durable medical equipment, miscellaneous* (E1399) is used to describe transcutaneous vagus nerve stimulation.	
	InterQual® BH:Behavioral Health Services Vagus Nerve Stimulation (VNS)	Vagus nerve stimulation (VNS) involves the use of a pulse generator which is implanted subcutaneously within the chest wall. Thin, flexible wires are tunneled beneath the skin to the lower neck region and attached to the left vagus nerve. Preprogrammed, intermittent electrical pulses are transmitted to the brain via the vagus nerve. **IMPORTANT NOTE:** The Company considers VNS for intractable epilepsy to be medically	CPT Codes 61885†, 61888†, 64553†, 64568†, 64569†, 64570†, 95970†, 95976†, 95977† HCPCS Codes C1767†, C1778†, C1820†, C1826†, C1827†, L8679†, L8680†, L8685†, L8686†, L8687†, L8688†	

POLICY NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATE
		necessary when criteria in this InterQual® subset are met.	†When these codes are used to describe vagus nerve stimulation for behavioral health conditions.	

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, 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.

Sources of Information:

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services. Available at: https://www.ama-assn.org/amaone/cpt-current-procedural-terminology. Accessed September 23, 2025.
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals. Accessed September 23, 2025.
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets. Available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update. Accessed September 23, 2025.
- Medical Mutual Healthcare Technology Assessment Program Description. Available at: https://www.medmutual.com/-/media/908301A8044D420BB377375914643593.ashx. Accessed September 23, 2025.
- National Comprehensive Cancer Network. Available at: https://www.nccn.org/. Accessed September 23, 2025.
- PubMed, National Library of Medicine. Available at: https://pubmed.ncbi.nlm.nih.gov/. Accessed September 23, 2025.
- symplr Evidence Analysis. Available at: https://evidence.hayesinc.com/. Accessed September 23, 2025.
- UpToDate. Available at: https://www.uptodate.com/. Accessed September 23, 2025.
- U.S. Preventive Services Task Force. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/. Accessed September 23, 2025.

Applicable Code(s):	
CPT:	**See above.**
HCPCS:	**See above.**
ICD10 Procedure Codes:	**See above.**

Revised:

12/12/2024: Policy created.

09/23/2025: Sources of information updated.

04/24/2026: MCG references removed or replaced with InterQual or CMP references.

- A-0242, Electromagnetic Therapy removed.
- A-0289, MRI-Guided Focused Ultrasound Surgery, Uterus removed.
- A-0494, Spinal Distraction Devices replaced with CP:Procedures Interspinous Process Device with or without Open Decompression.
- A-0567, Ovarian and Internal Iliac Vein Embolization removed.
- A-0578, Migraine Headache, Surgical Treatment removed.
- A-0634, Bronchial Thermoplasty removed.
- A-0667, Bioimpedance Spectroscopy replaced with new CMP.
- A-0718, Radiofrequency Ablation of Tumor - Thyroid Nodules removed.
- A-0727, Intrapulmonary Percussive Ventilation (IPV) removed.
- A-0998, Vagus Nerve Stimulation, Transcutaneous replaced with CP:Durable Medical Equipment Trigeminal and Vagus Nerve Stimulator Devices, Noninvasive.
- A-1025, Saphenous Vein Ablation, Mechanical Occlusion Chemical Ablation (MOCA) removed.
- A-1050, EEG, Quantitative (Brain Mapping) removed.
- B-821-T, Vagus Nerve Stimulation, Implantable: Behavioral Health Care replaced with BH:Behavioral Health Services Vagus Nerve Stimulation (VNS).