MEDICAL MUTUAL®

Medical Policy

SERVICES LISTED IN THIS CORPORATE MEDICAL POLICY ARE CONSIDERED INVESTIGATIONAL/EXPERIMENTAL

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:

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
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 include (but are not limited to) ~~p~~plantar fasciitis, shoulder tendonitis, Achilles' tendinopathy, and lateral epicondylitis.	CPT Codes 28890, Category III 0101T, 0102T, 0512T, 0513T	02/23/2024
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 in an effort to achieve tolerance to the allergy-causing substance. Theoretical advantages include a lower risk of	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	02/10/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		serious side effects and better patient acceptance.	covered, please see Drug Policy **Sublingual Allergen Extract 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.	10/13/2023
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	CPT 43201, 43210, 43236, 43284, 43289, 43257, 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.	04/07/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES

		regurgitation symptoms, thereby resolving esophagitis.
		
		Endoscopic and laparoscopic therapies may be classified into four basic categories as outlined below, with some examples (NOTE: this list is not all-inclusive):
		
		• Radiofrequency energy:
		  ○ Stretta®
		• Endoscopic plication/suturing
		  ○ Bard® EndoCinch™ Suturing System
		  ○ NDO Surgical Endoscopic Plication™ System
		  ○ The EndoGastric Solutions (EGS) Transoral Incisionless Fundoplication (TIF) EsophyX™ with SeroFuse™ Fastener
		• Polymer injection
		  ○ Ethylene-vinyl alcohol co-polymer (Enteryx®)
		  ○ Hydrogel prosthesis (Gatekeeper™ Reflux Repair System)
		• Laparoscopic magnetic sphincter augmentation
		  ○ LINX device (LINX™ Reflux Management System)		

MEDICAL MUTUAL®

Medical Policy

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
200403	Bone Graft Materials for Spinal Fusion and Bone Healing	Bone grafts are used in a variety of surgical procedures including the repair of non-healing fractures, bone defects due to infection, trauma, and other abnormalities as well as joint problems. Certain bone graft materials are covered and are found in CMP 200403. Based upon our findings, the Company considers the following bone graft materials **investigational** and **not** eligible for reimbursement: • Cell-based or viable allograft products including mesenchymal stem cells and human amniotic tissue materials (often termed cellular bone matrix (CBM) or viable bone matrix (VBM)) • Ceramic-based products used alone or with other graft materials Growth factors other than BMP-2 and synthetic peptides	CPT Codes 22899†, 27899† †When *unlisted procedure, spine* (22899) and *unlisted procedure, leg or ankle* (27899) is determined to be for cell-based or viable allograft products, ceramic-based products or growth factors and synthetic peptides.	5/31/2023
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	07/28/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
CMP 2006-D	Radiofrequency microtenotomy	Radiofrequency microtenotomy (radiofrequency-based microtenotomy) is a minimally invasive procedure for treatment of chronic tendinosis. Coblation® (ArthroCare® Corporation, Austin, TX) technology, a controlled, non-heat driven process, uses radiofrequency energy in an attempt to stimulate healing by initiating an inflammatory response in damaged tissue. A damaged tendon is surgically exposed and radiofrequency energy is directly applied to the tendon surface with a TOPAZ® MicroDebrider probe (ArthroCare® Corporation, Austin, TX) at 0.5 second intervals. Radiofrequency microtenotomy has been evaluated for the treatment of chronic tendinosis refractory to conventional therapy, including the supraspinatus tendon, forearm extensor muscle aponeurosis (at lateral epicondyle), patellar tendon, Achilles tendon and plantar fascia.	CPT Codes 20999†, 23929†, 24999†, 27599†, 27899† and 28899† are considered investigational and not eligible for reimbursement. †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 radiofrequency microtenotomy for tendinosis.	08/03/2023
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	CPT 92499 HCPCS S0515	12/14/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		space 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., Surgisis® AFP™ Anal Fistula Plug, Cook Anal Fistula Plug, Gore 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 Code 46707	05/17/2023
201004	Peripheral Nerve Stimulation (percutaneous or implanted) and Electrical Stimulation for Chronic Intractable Pain and Other Conditions	Peripheral nerve stimulation (PNS) involves surgical or percutaneous insertion of an electrode along a specific peripheral nerve determined to be responsible for regional pain. The electrode is connected to a lead that is tunneled to a receiver unit located within a subcutaneous pocket. Electrical impulses generated by a stimulator attached to the skin overlying the receiver are transmitted along the electrode to the peripheral nerve, thereby blocking or masking pain sensation. Peripheral nerve stimulation is a covered procedure and is found in CMP 201004.	CPT Codes 0278T, 0720T, 64555†, 64590†, 64999†† HCPCS Codes A4540, A4541, E0733, E1399††, S8103, S8131 †When *percutaneous implantation of electrode array; peripheral nerve* (CPT Code 64555) or *insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling* (CPT Code 64590) is determined to be for the ReActiv8	01/01/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		Based upon our findings, the Company considers the following electrical stimulators and stimulation therapy investigational: • Peripheral nerve stimulation using the ReActiv8 Implantable Neurostimulation System and the StimQ Peripheral Nerve Stimulator System • Peripheral nerve field stimulation (PNFS) and percutaneous electrical nerve field stimulation (PENFS) (e.g., IB-Stim) • Percutaneous neuromodulation therapy (e.g. Vertis Percutaneous Neuromodulation Therapy) • Interferential therapy (e.g. RS-4i Sequential Stimulator) • Transcutaneous electrical modulation pain reprocessing (e.g., Scrambler therapy) • Electrical stimulation for treatment of headaches or migraines.	Implantable Neurostimulation System. ††When *unlisted procedure, nervous system* (CPT Code 64999), *durable medical equipment, miscellaneous* (HCPCS Code E1399) is determined to be for PNFS, PENFS, percutaneous neuromodulation therapy or interferential therapy.	
2011-C	Wireless Gastrointestinal Motility Monitoring System	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	CPT Code 91112	03/27/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	-Suspected Gastric Motility Disorders	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.		
2013-C	Tenex Health TX Procedure	Tenex Health TX Procedure employs a minimally invasive technique intended to treat symptomatic tendon and soft tissue injuries that are unresponsive to conventional medical therapy. The procedure involves percutaneous insertion of the TX1 MicroTip™ through a 3mm 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, thereby reportedly alleviating tendon pain.	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 focused aspiration of scar tissue.	**11/28/2023**
2014-A	Non-Surgical Treatments for OSA - Oral Pressure Therapy - Electrical Muscle Training	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 the treatment of obstructive sleep apnea.	HCPCS A7002†, A7047†, E0600†,E490,E491 E0492 ,E0493, E0530 † When *tubing used with suction pump, each* (A7002) or *oral interface used*	07/11/2023 Code updated 12/07/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	- Positional Obstructive Sleep Apnea (POSA)	Electrical muscle training uses a device (eXcite[OSA], Rotech Healthcare Inc.) that delivers 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 positional obstructive sleep apnea (POSA) can be worn around the neck or chest alerting the user after falling asleep in any sleep position, gentle vibrations alert when the wearer is back-sleeping. *Night Shift, Luona, Zzoma*	*with respiratory suction pump, each* (A7047) or *respiratory suction pump, home model, portable or stationary, electric* (E0600) is determined to be oral pressure therapy for treatment of obstructive sleep apnea.	
2015-D	Hydrogen Breath Test for Irritable Bowel Syndrome	Hydrogen breath tests (HBTs) can be assessed by obtaining breath samples before and after the ingestion of various carbohydrate substrates (lactulose, lactose, glucose, sucrose, fructose, xylose, rice flour). Malabsorption of the substrate in the small intestine or an excess of bacteria in the small bowel can produce large amounts of hydrogen (H2), which is absorbed into the bloodstream and then expired through the breath. Breath samples are analyzed for H2 content by gas chromatography. Detection of expelled H2 can be symptomatic of malabsorption, small intestinal bacterial overgrowth (SIBO), or carbohydrate intolerance.	CPT 91065[†] [†]When *breath hydrogen or methane test* (91065) is determined to be hydrogen breath tests for the detection of irritable bowel syndrome.	06/26/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
2016-B	Powered Upper Extremity Orthotic Devices • Myoelectric • Brain-Computer Interface	Myoelectric orthotic mobility systems (e.g., MyoPro®, Myomo e100, mPower 1000, Myomo, Inc., Cambridge, MA) 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. Sensors are placed on the skin to detect weak muscle signals, which drive limb movement via electric motors located in the brace. Myoelectric orthotic mobility systems may help weak or paralyzed individuals to regain function and perform activities of daily living. Therapeutic brain-computer interface technology aims to assist stroke recovery by translating electrical activity in the motor cortex of the brain to movement of a robotic assistive device or orthotic that guides an extremity. IpsiHand Upper Extremity Rehabilitation System™ is an example of this approach. The noninvasive IpsiHand System detects electrical activity with electroencephalography and uses that information to drive an orthotic handpiece, thereby allowing the patient to engage in voluntary grasping movements.	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 specified (L7499) is determined to be myoelectric upper limb orthotic devices.	03/22/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
2017-B	Leadless Cardiac Pacemaker Systems (i.e., MicraTM Transcatheter Pacemaker System, Aveir VR Leadless System)	Leadless cardiac pacemaker systems are miniaturized, full featured single or dual chamber pacemakers that are implanted directly in the right ventricle and right atrium in the case of dual chamber pacemakers. They are thought to provide treatment options for patients with Class I or Class II indication for bradycardia pacing therapy without the increased risk for infection. **For Medicare Advantage members only**: approval may be permitted if the member is participating in an FDA-approved post approval trial that is registered.	CPT 33274, 33275, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 0823T, 0824T, 0825T, and 0826T	03/16/2024
2018-C	Actigraphy	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	06/09/2023
201913	Investigational Treatments for Benign Prostatic Hypertrophy	Benign prostatic hypertrophy (BPH) is a condition in which the prostate gland and surrounding tissues are enlarged which can impair the flow of urine from the urethra. Although not cancerous, the	CPT codes 37241†, 37242†, 37243†, 53855	05/09/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		growth can cause uncomfortable urinary symptoms such as bladder, urinary and kidney problems. There are now several non-surgical treatments for BPH. These treatments are intended for men whose symptoms are refractory to medical therapy and/or who are inappropriate candidates for more invasive procedures or who do not wish to undergo these procedures. Several treatments for benign prostatic hypertrophy, including Urolift, Rezum and Aquablation are covered procedures and are found in CMP 201913. Based upon our findings, the Company considers the following treatments for benign prostatic hypertrophy investigational: • Temporary prostatic urethral stents (e.g. Spanner Prostatic Stent, iTind) Prostatic artery embolization	†When v*ascular embolization or occlusion; venous, other than hemorrhage* (37241), *vascular embolization or occlusion; arterial, other than hemorrhage or tumor* (37242), *vascular embolization or occlusion; for tumors, organ ischemia, or infarction* (37243) is found to be prostatic artery embolization	
2019-A	Wireless pulmonary artery pressure monitoring (CardioMEMS)	The CardioMEMS HF System is intended to wirelessly monitor pulmonary artery pressure and heart rate in New York Heart Association class III heart failure patients who have been hospitalized for heart failure in the previous year.	CPT Codes 33289, 93264 HCPCS Code C2624	01/30/2024
2019-B	Subchondroplasty ® (SCP®) with AccuFill® Bone	The Subchondroplasty® Procedure (SCP®) is a minimally invasive, fluoroscopically assisted procedure in	CPT Codes 0707T, 29855†, 29856†, 29892†	03/31/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	Substitute Material (BSM)	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.	†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.	
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, Q4170 †When *unlisted procedure, nervous system (CPT 64999)*	06/15/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		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.	is determined to be 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) • Automated Percutaneous Lumbar Discectomy	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 MCG criteria (S-820). See also MCG™ Care Guideline® A-0494: Spinal Distraction Devices.	CPT 22586, 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 facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar (62380), laminotomy/decompression nerve root(s); one interspace,*	02/29/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	• Endoscopic Disc Decompression • Laser Disc Decompression • Minimally Invasive Lumbar Decompression (mild®)* • Nucleoplasty Disc Decompression **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.*		*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	CPT Codes 20560, 20561	05/09/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		are needed to demonstrate its safety and effectiveness.		
202011	Microsurgical Treatments for Lymphedema – Lymphatic Bypass Procedures	Lymphedema refers to the accumulation of fluid in tissues with inadequate lymphatic drainage, 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, and lymphatic-capsular-venous anastomosis.	CPT Codes 15756†, 35206†, 35226†, 35236†, 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.	06/27/2023
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	CPT Codes 0600T, 0601T, 47399† ICD 10 Procedure Codes 0F500ZF-	Effective: 11/01/2023 Revised: 09/06/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		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.	0F504ZF, 0F510ZF-0F514ZF, 0F520ZF-0F524ZF, 0F5G0ZF-0F5G4ZF †When *unlisted procedure, liver* (47399) is determined to be irreversible electroporation	
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	02/26/2024
202101	Peroral Endoscopic Myotomy (POEM)	Peroral endoscopic myotomy (POEM) is a minimally invasive surgical technique. POEM involves guiding an endoscope through the esophagus, making an incision in the mucosa and creating a submucosal tunnel to the lower esophagus and gastroesophageal junction, and then cutting the muscle fibers in the lower esophagus and proximal stomach. The internal incisions are closed with clips after myotomy is complete. This technique is regarded as	CPT Code 43499†, 43999† †When *unlisted procedure, esophagus* (43499), *unlisted procedure, stomach* (43999) is determined to be D-POEM, G-POEM or Z-POEM.	04/20/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		the endoscopic equivalent of the Heller myotomy. Per-oral endoscopic myotomy (POEM) is a covered procedure and is found in CMP 202101. The following POEM procedures are considered investigational: • Diverticular peroral endoscopic myotomy (D-POEM) • Gastric peroral endoscopic myotomy (G-POEM) • Zenker peroral endoscopic myotomy (Z-POEM)		
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	01/01/2024
202203	Non- pneumatic compression devices	Non-pneumatic compression devices (e.g., Koya Dayspring System) are a wearable compression system that uses sequential gradient compression for the treatment and management of patients with lymphedema. They are intended to promote lymph flow and maintain patient mobility during treatment.	HCPCS Codes K1024, K1025, K1031-K1032-K1033 E0677	04/17/2023
202204	Intravascular Lithotripsy (IVL)	Intravascular lithotripsy (IVL) is a procedure used to open narrow or	CPT Code 92972 and HCPCS Codes	01/26/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		blocked arteries due to calcification prior to stent implantation. The procedure is 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.	C9764, C9765, C9766, C9767, C9772, C9773, C9774, C9775, C1761	
202205	Implanted cardiac contractility modulation generator	The Optimizer® smart system is a minimally invasive device designed for cardiac contractility modulation (CCM) therapy for the treatment of severe chronic heart failure. The Optimizer® is a rechargeable pulse generator, the device is implanted into the patient's right ventricle septum with two lead configurations. The device is powered by an external charging station, the device uses a lithium-ion battery with 0.2Ah usable capacity. The treating physician programs the device to meet the patient's individual needs. The Optimizer® is the size of a pacemaker and can be inserted as an out-patient procedure.	CPT Code 0408T, HCPCS Code K1030	04/17/2023
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	02/09/2024

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		acromioplasty, and biceps tenodesis when performed.		
A-0242	Electromagnetic Therapy MCG™ Care Guideline® 26th Edition	Pulsed electromagnetic field therapy is a noninvasive, adjunctive therapy utilized to accelerate improvement and stimulate healing in chronic, nonhealing dermal ulcers unresponsive to conventional wound therapy.	HCPCS E0761, E0769, G0295, G0329	06/15/2023
A-0289	MRI-Guided Focused Ultrasound Surgery, Uterus MCG™ Care Guideline® 26th Edition	Magnetic resonance imaging-guided high-intensity focused ultrasound ablation is a noninvasive procedure developed to ablate uterine fibroid tissue.	CPT Codes 0071T, 0072T	06/15/2023
A-0494	Spinal Distraction Devices MCG™ Care Guideline® 26th Edition	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	06/15/2023
A-0567	Ovarian and Internal Iliac Vein Embolization	Pelvic congestion syndrome (PCS) is characterized by chronic pelvic pain that is unexplained by other etiologies. PCS may develop due to varicosities and/or valvular incompetence within the pelvic veins. Embolization of the ovarian vein and/or	CPT Codes 37241, 75894, 75898	06/15/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	MCG™ Care Guideline® 26th Edition	internal iliac vein is a treatment approach that involves the use of embolic agents to reroute blood flow, aiming to reduce pressure within the targeted veins.		
A-0578	Migraine Headache, Surgical Treatment MCG™ Care Guideline® 26th Edition	Migraine, cluster and other headache syndromes are common, often debilitating, primary headache disorders. Surgical interventions have been proposed for the prevention, reduction or elimination of these headache types. Similar therapies have been proposed for tension-type headaches and occipital neuralgia. Examples of these procedures include: resection or manipulation of facial muscles or soft tissue from the forehead, periorbital, occipital or other facial or scalp areas; resection of the trigeminal nerve or its branches; surgical modification of the sinuses; and patent foramen ovale closure.	CPT: 15824, 15826, 21299, 30130, 30140, 30520, 30801, 30802, 31200, 31201, 31205, 31254, 31255, 64732, 64734, 64744, 67900, 93580 (or any codes found to be for services listed)	06/15/2023
A-0634	Bronchial Thermoplasty MCG™ Care Guideline® 26th Edition	Bronchial thermoplasty (Alair® Bronchial Thermoplasty System, Boston Scientific, Sunnyvale, CA) is a procedure purported to weaken and partially destroy the airway smooth muscle responsible for the bronchoconstriction associated with asthma attacks. A course of bronchial thermoplasty usually consists of several treatment sessions performed under moderate sedation by a pulmonologist for adults with severe persistent asthma that has not been well controlled by conventional medical	CPT 31660 and 31661	06/15/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		therapy, including optimal doses of long-acting bronchodilators and glucocorticoids.		
A-0667	Bioimpedance Spectroscopy MCG™ Care Guideline® 26th Edition	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 (e.g., ImpediMED L-Dex U400 BIS Extra Cellular Fluid Analyzer, ImpediMed Limited, Queensland Australia; San Diego, CA). 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 0358T, 93702	06/15/2023
A-0709 & A-0858	Proteomics – Ovarian Cancer Biomarker Panel (OVA1 & ROMA)	Proteomics-based ovarian adnexal mass assessment score test systems (e.g., OVA1™ Test, ROMA™ test) measure one or more serum proteins believed to preoperatively predict the likelihood that an ovarian adnexal mass represents ovarian cancer. These systems have been proposed as being useful in the	CPT 0003U, 81500, 81053 and 96040 HCPCS S0265	06/15/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
	MCG™ Care Guideline® 26th Edition	preoperative assessment of a pelvic mass suspicious for ovarian cancer and have been reported to augment identification of individuals requiring gynecologic oncology surgical expertise.		
A-0718	Radiofrequency Ablation of Tumor - Benign thyroid nodules MCG™ Care Guideline® 26th Edition	Radiofrequency ablation (RFA) uses high frequency alternating current to induce thermal injury and cell death in a targeted area of tissue. It may be performed percutaneously or surgically via laparoscopy or laparotomy, and CT, MRI, or ultrasound may be used for guidance. For RFA of benign thyroid nodules, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.	0600T, 0601T, 60699†, 76940†, C1886† †When *unlisted procedure, endocrine system* (60699), *ultrasound guidance for parenchymal tissue ablation* (76940), or *catheter, ablation* (C1886) is used to describe radiofrequency ablation of benign thyroid nodules.	06/15/2023
A-0727	Intrapulmonary Percussive Ventilation (IPV) MCG™ Care Guideline® 26th Edition	Intrapulmonary percussive ventilation (IPV) is a breathing system that attempts to loosen mucus by internally percussing the airways through the delivery of high-frequency, high-flow, low-pressure bursts of gas in an oscillating fashion to a spontaneously breathing patient via mask, mouthpiece, or tracheostomy; it is most commonly used in patients on mechanical ventilation. Aerosolized bronchodilators or other medications can be delivered in these bursts of gas. Airway clearance is thought to result from improved lung expansion and	CPT Code 94640 and HCPCS Code E0481	06/15/2023

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
		creation of vibrations within the airways that loosen mucus and secretions.		
A-0998	Vagus Nerve Stimulation, Transcutaneous MCG™ Care Guideline® 26th Edition	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 Code E1399†, E0735, K1020 †When *durable medical equipment, miscellaneous* (E1399) is used to describe transcutaneous vagus nerve stimulation.	01/01/2024
A-1025	Saphenous Vein Ablation, Mechanical Occlusion Chemical Ablation (MOCA) MCG™ Care Guideline® 26th Edition	Mechanical occlusion chemical ablation (MOCA) of the saphenous vein is a nonthermal technique that combines mechanical epithelial injury via a catheter-directed rotating wire with concomitant chemical ablation via simultaneous administration of a sclerosing agent (e.g., sodium tetradecyl sulfate, polidocanol) over the rotating wire. Ultrasonography is used to continuously guide the procedure. For saphenous vein incompetence, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.	CPT Codes 36473, 36474	06/15/2023
A-1039	Transcervical Uterine Ablation of Leiomyomas MCGTM Care Guideline® 27th Edition	Transcervical uterine ablation of leiomyomas relies on ultrasound guidance coupled with targeted intrauterine radiofrequency ablation to cause coagulative necrosis within the treated leiomyoma.	CPT Code 58580	01/09/2024

MEDICAL MUTUAL®

Medical Policy

NUMBER	TITLE	DESCRIPTION	APPLICABLE CODE(S)	EFFECTIVE/ REVISED DATES
B-821-T	Vagus Nerve Stimulation, Implantable: Behavioral Health Care MCG™ Care Guideline® 26th Edition	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.	CPT Codes 61885†, 61888†, 64553†, 64568†, 64569†, 64570†, 95970†, 95976†, 95977† HCPCS Codes C1767†, C1778†, C1820†, L8679†, L8680†, L8685†, L8686†, L8687†, L8688† †When these codes are used to describe vagus nerve stimulation for behavioral health conditions.	06/15/2023

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: The Company reserves the right to apply this policy to the procedure performed regardless of how the procedure was coded by the provider.