Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and is therefore subject to change.

***Current Policy Effective Date: 11/1/22**
(See policy history boxes for previous effective dates)

Title: CPT Category III Codes-Noncovered Services

Description/Background

CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. These codes are intended to be used for data collection to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. Category III codes are different from Category I CPT codes in that they identify services that may not be performed by many health care professionals across the country, some may not have FDA approval, and some services/procedure have no proven clinical efficacy.

The inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety, or the applicability to clinical practice.

Regulatory Status

N/A

Medical Policy Statement

The procedures, services and/or tests in this policy have been determined to be experimental/investigational. They are not a covered benefit for all contracts that exclude reimbursement for experimental/investigational services.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

I. Governmental approval of a service will be considered in determining whether a service is experimental or investigational. The fact that a service has received governmental approval does not necessarily mean that it is of proven benefit or appropriate or effective treatment for a particular diagnosis or for a particular condition.

II. In determining whether there is rigorous scientific evidence to determine if a service is or is not experimental or investigational, we require that all of the following five criteria be met:
   a. A service that is a medical device, drug, or biological product must have received final approval from the appropriate government regulatory bodies; such as the United States Food and Drug Administration (FDA). Any other approval granted as an interim step in the FDA regulatory process (e.g., an Investigational Device Exemption or an Investigational New Drug Exemption) is not sufficient.
   b. Published, peer-reviewed, medical literature must provide conclusive evidence that the service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
   c. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the service leads to improvement in health outcomes (e.g., the beneficial effects of the service outweigh any harmful effects).
   d. Published, peer-reviewed medical literature must provide proof that the service is at least as effective in improving health outcomes as established services or technologies or is usable in appropriate clinical contexts in which an established service or technology is not employable.
   e. Published, peer-reviewed medical literature must provide proof that improvement in health outcomes is possible in standard conditions of medical practice, outside of clinical investigatory settings.

III. The Federal Employee Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only based on their medical necessity.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

N/A

Other codes (investigational, not medically necessary, etc.):

Multiple

Note: Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.

Rationale

The use of a service, procedure or supply that is not recognized as standard medical care for the condition, disease, illness or injury being treated is considered an experimental/investigational service.

A service is considered experimental/investigational if any of the following criteria are met:

1. The services, procedures or supplies requiring Federal or other Governmental body approval, such as drugs and devices, do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
2. There is insufficient or inconclusive medical and scientific evidence that permits the evaluation of the therapeutic value of the service, procedure or supply. (Adequate evidence is defined as **at least two** documents of medical and scientific evidence that indicate that the proposed treatment is likely to be beneficial to the member.)
3. There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the service, procedure or supply has a beneficial effect on health outcomes.
4. The service, procedure or supply under consideration is not as beneficial as any established alternatives.
5. There is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the service, procedure or supply has a beneficial effect on health outcomes or is as beneficial as any established alternatives.

The following CPT category III codes are excluded from coverage and considered experimental/investigational due to lack of literature establishing clinical efficacy, safety, or the applicability to clinical practice.

Table 1. CPT Category III Codes That are Noncovered Due to Experimental/Investigational Status

Code	Policy (If Applicable)
0054T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0055T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0071T	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)
0072T	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS)
0075T	Endovascular Therapies for Extracranial Vertebral Artery Disease
0076T	Endovascular Therapies for Extracranial Vertebral Artery Disease
0098T	Artificial Intervertebral Disc-Cervical Spine
0101T	Extracorporeal Shock Wave Therapy for Treatment of Plantar Fasciitis and other Musculoskeletal Disorders
0102T	Extracorporeal Shock Wave Therapy for Treatment of Plantar Fasciitis and other Musculoskeletal

	Disorders
0106T	Quantitative Sensory Testing (QST)
0107T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0108T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0109T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0110T	Computer Assisted Musculoskeletal Surgical Navigational Orthopedic procedure
0111T	
0163T	Artificial Intervertebral Discs-Lumbar Spine
0164T	Artificial Intervertebral Discs-Lumbar Spine
0165T	Artificial Intervertebral Discs-Lumbar Spine
0174T	Screening for Lung Cancer Using CT Scans-Chest-Rays
0175T	Screening for Lung Cancer Using CT Scans-Chest-Rays
0198T	
0200T	Percutaneous Sacral Augmentation
0201T	Percutaneous Sacral Augmentation
0202T	
0207T	Eyelid Thermal Pulsation and Interferometric Color Assessment of the Tear Film for the Diagnosis and Treatment of Dry Eye Syndrome
0208T	Automated Audiometry
0209T	Automated Audiometry
0210T	Automated Audiometry
0211T	Automated Audiometry
0212T	Automated Audiometry
0219T	Posterior Intrafacet Implant
0220T	Posterior Intrafacet Implant
0221T	Posterior Intrafacet Implant
0222T	Posterior Intrafacet Implant
0232T	
0253T	Aqueous Shunts and Stents for Glaucoma
0263T	Stem Cell Therapy in the Treatment of Peripheral Artery Disease
0264T	Stem Cell Therapy in the Treatment of Peripheral Artery Disease
0265T	Stem Cell Therapy in the Treatment of Peripheral Artery Disease
0266T	Baroreflex Stimulation Devices
0267T	Baroreflex Stimulation Devices
0268T	Baroreflex Stimulation Devices
0269T	Baroreflex Stimulation Devices
0270T	Baroreflex Stimulation Devices
0271T	Baroreflex Stimulation Devices
0272T	Baroreflex Stimulation Devices
0273T	Baroreflex Stimulation Devices
0274T	
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Scrambler Therapy)
0312T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0313T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0314T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0315T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0316T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0317T	Vagus Nerve Blocking for the Treatment of Morbid Obesity
0329T	Continuous Intraocular Pressure Monitoring
0330T	Eyelid Thermal Pulsation and Interferometric Color Assessment of the Tear Film for the Diagnosis and Treatment of Dry Eye Syndrome
0331T	Myocardial Sympathetic Innervation Imaging
0332T	Myocardial Sympathetic Innervation Imaging
0333T	Automated Visual Evoked Potentials for Routine Vision Screening in Pediatrics

0335T	Subtalar Arthroeresis
0338T	Radiofrequency Ablation of the Renal Sympathetic Nerves as a treatment for Resistant Hypertension
0339T	Radiofrequency Ablation of the Renal Sympathetic Nerves as a treatment for Resistant Hypertension
0342T	
0347T	Radiostereometric Analysis (RSA)
0348T	Radiostereometric Analysis (RSA)
0349T	Radiostereometric Analysis (RSA)
0350T	Radiostereometric Analysis (RSA)
0351T	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes
0352T	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes
0353T	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes
0354T	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes
0358T	
0378T	Home Monitoring Device for Age-Related Macular Degeneration
0379T	Home Monitoring Device for Age-Related Macular Degeneration
0394T	Electronic Brachytherapy
0395T	Electronic Brachytherapy
0397T	Confocal Laser Endomicroscopy
0403T	
0408T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0409T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0410T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0411T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0412T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0413T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0414T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0415T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0416T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0417T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0418T	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting
0421T	Aquablation of the Prostate
0422T	Tactile Breast Imaging by Computer-Aided Tactile Sensors
0423T	Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk, Measurement of
0424T	Phrenic Nerve Stimulation For Central Sleep Apnea
0425T	Phrenic Nerve Stimulation For Central Sleep Apnea
0426T	Phrenic Nerve Stimulation For Central Sleep Apnea
0427T	Phrenic Nerve Stimulation For Central Sleep Apnea
0428T	Phrenic Nerve Stimulation For Central Sleep Apnea
0429T	Phrenic Nerve Stimulation For Central Sleep Apnea
0430T	Phrenic Nerve Stimulation For Central Sleep Apnea
0431T	Phrenic Nerve Stimulation For Central Sleep Apnea
0432T	Phrenic Nerve Stimulation For Central Sleep Apnea
0433T	Phrenic Nerve Stimulation For Central Sleep Apnea
0434T	Phrenic Nerve Stimulation For Central Sleep Apnea
0435T	Phrenic Nerve Stimulation For Central Sleep Apnea
0436T	Phrenic Nerve Stimulation For Central Sleep Apnea
0437T	
0439T	
0440T	Cryoablation of Peripheral Nerves
0441T	Cryoablation of Peripheral Nerves
0442T	Cryoablation of Peripheral Nerves
0443T	Spectral Analysis of Prostate Tissue
0444T	
0445T	
0465T	Suprachoroidal Delivery of Pharmacologic Agent

0470T	
0471T	
0472T	Retinal Prosthesis
0473T	Retinal Prosthesis
0475T	Fetal Magnetocardiography (F-MCG)
0476T	Fetal Magnetocardiography (F-MCG)
0477T	Fetal Magnetocardiography (F-MCG)
0478T	Fetal Magnetocardiography (F-MCG)
0481T	
0483T	
0484T	
0485T	Optical Coherence Tomography of the Middle Ear (e.g., PhotoniCare ClearView® System)
0486T	Optical Coherence Tomography of the Middle Ear (e.g., PhotoniCare ClearView® System)
0487T	
0488T	
0489T	
0490T	
0491T	
0492T	
0493T	Near-Infrared Spectroscopy for Wound Examination
0494T	Ex-Vivo Lung Perfusion (EVLP)
0495T	Ex-Vivo Lung Perfusion (EVLP)
0496T	Ex-Vivo Lung Perfusion (EVLP)
0497T	
0498T	
0499T	
0500T	
0505T	
0506T	
0507T	
0508T	
0509T	
0510T	Subtalar Arthroereisis
0511T	Subtalar Arthroereisis
0512T	Extracorporeal Shock Wave Treatment Of Wounds
0513T	Extracorporeal Shock Wave Treatment Of Wounds
0514T	
0515T	
0516T	
0517T	
0518T	
0519T	
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0538T	
0541T	
0542T	
0543T	Transcatheter Mitral Valve Repair
0544T	Transcatheter Mitral Valve Repair
0545T	
0546T	Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery (e.g., MarginProbe®)
0547T	
0553T	
0554T	
0555T	
0556T	
0557T	
0558T	
0559T	
0560T	
0561T	
0562T	
0563T	Eyelid Theramal Pulsation and Interferometric Color Assessment of the Tear Film for Dry Eye
0564T	Chemosensitivity and Chemoresistance Assay, In Vitro
0565T	Autografts and allografts in the Treatment of Focal Articular Cartilage Lesions
0566T	Orthopedic Applications of Stem-Cell Therapy
0567T	
0568T	
0569T	
0570T	
0571T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0572T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0573T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0574T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0575T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0576T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0577T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0578T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0579T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0580T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0581T	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate or Dermologic Tumors
0582T	Focal Treatments for Prostate Cancer
0583T	Balloon Dilation of the Eustachian Tube (BDET)
0591T	
0592T	
0593T	
0594T	
0596T	
0597T	
0598T	Non-contact ultrasound for the treatment of wounds
0599T	Non-contact ultrasound for the treatment of wounds
0600T	
0601T	
0602T	
0603T	
0604T	Optical coherence tomography imaging, anterior eye
0605T	Optical coherence tomography imaging, anterior eye
0606T	Optical coherence tomography imaging, anterior eye
0607T	Cardiac hemodynamic monitoring for the management of heart failure in the outpatient setting
0608T	Cardiac hemodynamic monitoring for the management of heart failure in the outpatient setting

0609T	Magnetic resonance spectroscopy
0610T	Magnetic resonance spectroscopy
0611T	Magnetic resonance spectroscopy
0612T	Magnetic resonance spectroscopy
0613T	
0614T	Implantable Cardioverter Defibrillator (ICD), Including Subcutaneous ICDs
0615T	
0616T	Intraocular lens implant for myopia (nearsightedness)
0617T	Intraocular lens implant for myopia (nearsightedness)
0618T	Intraocular lens implant for myopia (nearsightedness)
0619T	
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0631T	
0632T	
0633T	
0634T	
0635T	
0636T	
0637T	
0638T	
0639T	
0640T	Near Infrared Spectroscopic Examination of Wounds
0641T	Near Infrared Spectroscopic Examination of Wounds
0642T	Near Infrared Spectroscopic Examination of Wounds
0643T	
0645T	
0646T	
0647T	
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0649T	
0650T	Ambulatory Event Monitor & Mobile Cardiac Outpatient Telemetry
0651T	Wireless Capsule Endoscopy
0655T	Focal Treatments for Prostate
0656T	Vertebral Body Tethering and/or Stapling for Scoliosis
0657T	Vertebral Body Tethering and/or Stapling for Scoliosis
0658T	
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Government Regulations

National:

No NCD available

Local:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35490&ver=40&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Michigan&KeyWord=category+III&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAA&

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

1. Centers for Medicare and Medicaid Services. Local Coverage Determination (L35490): Category III Codes. For services performed on or after 06/01/2018.
2. Excellus Blue Cross Blue Shield. Experimental or Investigational Services. Medical Policy. Published 09/16/99. Archived 02/26/09.
3. Blue Cross Blue Shield of Rhode Island. CPT Category III Codes. Medical Policy. Published 04/05/11, last updated 04/05/11.
4. American Medical Association. CPT® Category III Codes. Last updated January 2018.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through July 2022, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
11/1/18	8/21/18	8/21/18	Joint policy established
12/11/18	12/11/18		Removed questionable codes 0501T-0504T and 0095T.
2/19/19	2/19/19		Codes 0387T-0391T, 0346T deleted 1/1/19.
4/16/19	4/16/19		Codes 0479T and 0480T removed from policy as procedure is not E/I. Codes 0159T, 0188T-0196T, 0337T, 0406T and 0407T are deleted codes and therefore removed from policy. The following codes were removed from the policy because they are now payable: 0215T-0218T, 0235T-0238T and 0466T-0468T.
6/18/19	6/18/19		No new codes added/deleted.
8/20/19	8/20/19		Added E/I codes 0509T-0562T.
10/15/19	10/15/19		Deleted codes 0537T, 0539T and 0540T from policy.
12/17/19	12/17/19		Added codes 0563T-0583T and 0591T-0593T as E/I. Removed 0398T as now it is established.
2/18/20	2/18/20		Removed the following codes: 0205T, 0206T, 0254T, 0341T, 0357T, 0375T, 0377T, 0380T, 0482T.
4/14/20	4/14/20		No new codes added/deleted.
6/16/20	6/16/20		No new codes added/deleted.
8/18/20	8/18/20		Added codes 0594T-0619T as E/I.
10/1/20	10/15/20		Added codes 0620T-0639T as E/I. Removed code 0356T.
12/15/20	12/15/20		No codes added or deleted.
2/16/21	2/16/21		Deleted codes as of 1/1/2021: 0058T, 0085T, 0126T, 0228T-0231T, 0382T-0386T, 0396T, 0400T-0401T, and 0405T. Code 0601T nomenclature revised

4/20/21	4/20/21		Code 0552T removed from policy as this code is now payable.
6/15/21	6/15/21		Code 0381T deleted, Code 0404T now established and removed from this policy.
8/17/21	8/17/21		Codes 0640T-0670T added, effective 7/1/21. Code 0523T removed as it is a covered service.
10/19/21	10/19/21		Codes 0446T-0448T removed as they are now established.
12/14/21	12/14/21		No additions or deletions.
2/15/22	2/15/22		Added codes 0671T-0713T effective 1/1/22. Deleted codes 0290T, 0355T, 0356T, 0376T, 0423T, 0451T-0463T, 0466T-0468T, 0548T-0551T.
4/19/22	4/19/22		No additions or deletions, routine policy maintenance.
9/1/22	6/21/22		Added codes 0714T-0737T effective 7/1/22.
11/1/22	8/16/22		No additions removed reference to policy under code 0619T, routine policy maintenance.

Next Review Date: Every Qtr.

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN:	Revised:
BCBSM:	Revised:

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: CPT CATEGORY III CODES-NONCOVERED SERVICES

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
BCNA (Medicare Advantage)	See government section
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.