

Medicare Advantage Medical Policy



CPT Category III Codes - Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 05/20/2026
Effective Date: 06/20/2026

Description

CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. Their primary purpose is to support evidence-generation for widespread clinical use and to aid the U.S. Food and Drug Administration (FDA) approval process. When a Category III code exists for a service, it must be reported instead of an unlisted Category I code.

These codes enable physicians, qualified health-care professionals, insurers, researchers, and policy makers to:

- Identify new technologies and services.
- Track clinical efficacy, utilization, and outcomes.

The presence of a service in the Category III section does not imply endorsement of its safety, efficacy, or suitability for coverage. It simply reflects that the service is under investigation.

Regulatory Status

FDA approval is required for Medicare coverage, but it alone does not establish medical necessity. The FDA does not make Medicare coverage or payment decisions, and FDA statutes do not govern those decisions (Medicare PFS Final Rule CY2026, CMS-1832-F).

Medical Necessity: For any item or service—whether identified by a Category III code or otherwise—to be considered medically necessary, it must be:

- Consistent with the patient's diagnosis (symptoms, illness, or injury).
- Aligned with accepted professional standards of care (i.e., not experimental or investigational).
- Provided for clinical reasons, not merely for patient or provider convenience.
- Delivered at the most appropriate level of care that can be given safely and effectively.

CPT Code and Fee Schedule: Having a CPT code or payment amount in the Medicare fee schedule is also not sufficient for determining medical necessity. (42 CFR § 405.205)

Investigational Services: Services or devices lacking scientific evidence regarding safety and clinical efficacy/validity are considered non-covered and not reasonable and necessary (Medicare IOM Pub. No. 100-04, Ch. 23, §30 A). A treatment or procedure is considered not medically necessary if reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.

Internal Coverage Criteria: Medicare Advantage plans (e.g., BCBSM/ BCN) may establish their own coverage criteria based on current evidence in treatment guidelines and/or clinical literature when CMS coverage criteria are not fully established (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

Medicare Coverage of FDA-Approved Investigational Device Exemption (IDE) Studies: Coverage depends on the FDA's classification of the device:

- FDA Category A (Experimental) Medicare covers only routine care items/services; the investigational device itself is not covered because safety/effectiveness questions remain.
- FDA Category B (Nonexperimental/Investigational) Both the device and routine care may be covered if specific CMS-approved criteria are satisfied.

For additional information see:

- CMS National Coverage Determination (NCD) Routine Costs in Clinical Trials (310.1) at <https://www.cms.gov/medicare-coverage-database/search.aspx>
- Medicare Coverage Related to Investigational Device Exemption (IDE) Studies at <https://www.cms.gov/medicare/coverage/investigational-device-exemption-ide-studies>

Related Medical Coverage Policies

- Multiple, see guidance table below

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies consistent with 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at: <https://www.bcbsm.com/providers/mpradmin/> and by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: L38694, A58218 – Computed Tomography Cerebral Perfusion Analysis (CTP) First Coast: None NGS: L38667, A58152 - Computed Tomography Cerebral Perfusion Analysis (CTP) Noridian JE: L38709, A58223 - Computed Tomography Cerebral Perfusion Analysis (CTP) Noridian JF: L38700, A58225 - Computed Tomography Cerebral Perfusion Analysis (CTP) Novitas: None Palmetto: L38769, A58354 - Computed Tomography Cerebral Perfusion Analysis (CTP)
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) – Medicare Advantage Access at: https://www.bcbsm.com/providers/mpradmin/

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) – Medicare Advantage
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel.	Endovascular Therapies for Extracranial Vertebral Artery Disease – Medicare Advantage
0076T	Each additional vessel (List separately in addition to code for primary procedure).	Endovascular Therapies for Extracranial Vertebral Artery Disease – Medicare Advantage
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified.	Extracorporeal Shock Wave Therapy for Treatment of Plantar Fasciitis and other Musculoskeletal Disorders – Medicare Advantage
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	Extracorporeal Shock Wave Therapy for Treatment of Plantar Fasciitis and other Musculoskeletal Disorders – Medicare Advantage
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	Quantitative Sensory Testing (QST) – Medicare Advantage
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	Quantitative Sensory Testing (QST) – Medicare Advantage
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	Quantitative Sensory Testing (QST) – Medicare Advantage
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	Quantitative Sensory Testing (QST) – Medicare Advantage
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	Quantitative Sensory Testing (QST) – Medicare Advantage
0174T	Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with	Screening For Lung Cancer Using Computed Tomography Scanning (Spiral or Helical CT) or Chest Radiographs – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	primary interpretation (List separately in addition to code for primary procedure).	
0175T	Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation	Screening For Lung Cancer Using Computed Tomography Scanning (Spiral or Helical CT) or Chest Radiographs – Medicare Advantage
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEM), including muscularis propria (i.e., full thickness)	Transanal Endoscopic Microsurgery (TEM) – Medicare Advantage
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	Ophthalmologic Techniques that Evaluate the Posterior Segment for Glaucoma – Medicare Advantage
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	Percutaneous Sacral Augmentation – Medicare Advantage
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	Percutaneous Sacral Augmentation – Medicare Advantage
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	Facet Arthroplasty – Medicare Advantage
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	Thermal Treatments for Dry Eye Syndrome – Medicare Advantage
0208T	Pure tone audiometry (threshold), automated; air only	Hearing Services – Medicare Advantage
0209T	Pure tone audiometry (threshold), automated; air and bone	Hearing Services – Medicare Advantage
0210T	Speech audiometry threshold, automated	Hearing Services – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0211T	Speech audiometry threshold, automated; with speech recognition	Hearing Services – Medicare Advantage
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	Hearing Services – Medicare Advantage
0219T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	Facet Arthroplasty – Medicare Advantage
0220T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	Facet Arthroplasty – Medicare Advantage
0221T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	Facet Arthroplasty – Medicare Advantage
0222T	Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	Facet Arthroplasty – Medicare Advantage
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	NCD-CED: Coverage with Evidence Development NCD: 270.3 – Blood-Derived Products for Chronic non-healing wounds National Coverage Analysis (NCA) Decision Memo: CAG-00190R4: Autologous Blood-Derived Products for Chronic Non-Healing Wounds Devices are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence LCD/LCA: See Below WPS: None CGS: L39023, A58737 - Platelet Rich Plasma Injections for Non-Wound Injections First Coast: L39071, A58810 - Platelet Rich Plasma NGS: L38937, A58609 - Platelet Rich Plasma Noridian: L39058, A58788 Platelet Rich Plasma Injections for Non-Wound Injections

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		Novitas: L39068, A58808 - Platelet Rich Plasma Palmetto: L38745, A58282- Platelet Rich Plasma
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space [Solx Gold Shunt]	Aqueous Shunts and Stents for Glaucoma - Medicare Advantage
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, 1 leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	Stem Cell Therapy in the Treatment of Peripheral Artery Disease – Medicare Advantage
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, 1 leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	Stem Cell Therapy in the Treatment of Peripheral Artery Disease – Medicare Advantage
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, 1 leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	Stem Cell Therapy in the Treatment of Peripheral Artery Disease – Medicare Advantage
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes)	Transcutaneous Electrical Modulation Pain Reprocessing (Scrambler Therapy) – Medicare Advantage
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	Continuous Intraocular Pressure Monitoring – Medicare Advantage
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	Thermal Treatments for Dry Eye Syndrome – Medicare Advantage
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	Myocardial Sympathetic Innervation Imaging – Heart Failure – Medicare Advantage
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Myocardial Sympathetic Innervation Imaging – Heart Failure – Medicare Advantage
0333T	Visual evoked potential, screening of visual acuity, automated, with report	Automated Visual Evoked Potentials for Routine Vision Screening in Pediatrics – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0335T	Insertion of sinus tarsi implant	Subtalar Arthroereisis – Medicare Advantage
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural road mapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	NCDE-CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00470N Renal Denervation for Uncontrolled Hypertension is non-covered when furnished outside of a CMS approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural road mapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral.	NCDE-CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00470N Renal Denervation for Uncontrolled Hypertension is non-covered when furnished outside of a CMS approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0342T	Therapeutic apheresis with selective HDL de-lipidation and plasma reinfusion	Received limited, specialized FDA approval under a Humanitarian Device Exemption (HDE)
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Transcatheter Mitral Valve Procedures – Medicare Advantage
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes – Medicare Advantage
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes – Medicare Advantage
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes – Medicare Advantage
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	Optical Coherence Tomography of the Breast and/or Axillary Lymph Nodes – Medicare Advantage
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	Methods To Measure Body Composition (e.g., DXA, BIA and ADP) - Medicare Advantage
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage	Home Monitoring Device for Age-Related Macular Degeneration – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	with patient-initiated data transmitted to a remote surveillance center for up to 30 days: review and interpretation with report by a physician or other qualified health care professional	
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient-initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	Home Monitoring Device for Age-Related Macular Degeneration – Medicare Advantage
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed	Electronic Brachytherapy – Medicare Advantage
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	Confocal Laser Endomicroscopy – Medicare Advantage
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		For additional information, see https://www.cms.gov/medicare/coverage/evidence
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00469N Cardiac contractility Modulation (CCM) for Heart Failure management is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)	NCD: None LCD/LCA: See Below WPS: L38682, A58209 – Transurethral Waterjet Ablation of the Prostate CGS: L38378, A57926 – Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH) First Coast: L38726, A58624 - Transurethral Waterjet Ablation of the Prostate NGS: L38367, A56797 - Fluid Jet System Treatment for LUTS/BPH Noridian JE: L38705, A58227 - Transurethral Waterjet Ablation of the Prostate Noridian JF: L38707, A58229 - Transurethral Waterjet Ablation of the Prostate Novitas: L38712, A58243 - Transurethral Waterjet Ablation of the Prostate Palmetto: L38549, A58008 - Transurethral Waterjet Ablation of the Prostate

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	Tactile Breast Imaging – Medicare Advantage
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	Ablation of Peripheral Nerves to Treat Pain including Coolief Cooled RF and Iovera System – Medicare Advantage
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Ablation of Peripheral Nerves to Treat Pain including Coolief Cooled RF and Iovera System – Medicare Advantage
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)	Ablation of Peripheral Nerves to Treat Pain including Coolief Cooled RF and Iovera System – Medicare Advantage
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training	NCD: None LCD/LCA: See Below WPS: L38662, A58213 - Implantable Continuous Glucose Monitors (I-CGM) CGS: L38686, A58127 - Implantable Continuous Glucose Monitors (I-CGM) First Coast: L38664, A58136 - Implantable Continuous Glucose Monitors (I-CGM) NGS: L38623, A58116 - Implantable Continuous Glucose Monitors (I-CGM) Noridian JE: L38657, A58133 - Implantable Continuous Glucose Monitors (I-CGM) Noridian JF: L38659, A58138 - Implantable Continuous Glucose Monitors (I-CGM) Novitas: L38617, A58110 - Implantable Continuous Glucose Monitors (I-CGM) Palmetto: L38743, A58277 - Implantable Continuous Glucose Monitors (I-CGM)
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	NCD: None LCD/LCA: See Below WPS: L38662, A58213 - Implantable Continuous Glucose Monitors (I-CGM) CGS: L38686, A58127 - Implantable Continuous Glucose Monitors (I-CGM) First Coast: L38664, A58136 - Implantable Continuous Glucose Monitors (I-CGM) NGS: L38623, A58116 - Implantable Continuous Glucose Monitors (I-CGM)

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		Noridian JE: L38657, A58133 - Implantable Continuous Glucose Monitors (I-CGM) Noridian JF: L38659, A58138 - Implantable Continuous Glucose Monitors (I-CGM) Novitas: L38617, A58110 - Implantable Continuous Glucose Monitors (I-CGM) Palmetto: L38743, A58277 - Implantable Continuous Glucose Monitors (I-CGM)
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation	NCD: None LCD/LCA: See Below WPS: L38662, A58213 - Implantable Continuous Glucose Monitors (I-CGM) CGS: L38686, A58127 - Implantable Continuous Glucose Monitors (I-CGM) First Coast: L38664, A58136 - Implantable Continuous Glucose Monitors (I-CGM) NGS: L38623, A58116 - Implantable Continuous Glucose Monitors (I-CGM) Noridian JE: L38657, A58133 - Implantable Continuous Glucose Monitors (I-CGM) Noridian JF: L38659, A58138 - Implantable Continuous Glucose Monitors (I-CGM) Novitas: L38617, A58110 - Implantable Continuous Glucose Monitors (I-CGM) Palmetto: L38743, A58277 - Implantable Continuous Glucose Monitors (I-CGM)
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device, [AqueSys XEN Gel Stent AqueSys, Inc]	Aqueous Shunts and Stents for Glaucoma – Medicare Advantage
0450T	Each additional device (list separately in addition to code for primary procedure), [AqueSys XEN Gel Stent AqueSys, Inc]	Aqueous Shunts and Stents for Glaucoma – Medicare Advantage
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	Ophthalmologic Techniques that Evaluate the Posterior Segment for Glaucoma – Medicare Advantage
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Retinal Polarization Scan (Retinal Birefringence Scanning) – Medicare Advantage
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array in person, with iterative adjustment of the	Retinal Prosthesis – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	
0473T	Device evaluation and interrogation of intraocular retinal electrode array in person, including reprogramming and visual training, when performed, with review and report by a qualified healthcare professional.	Retinal Prosthesis – Medicare Advantage
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space [CyPass® Micro-Stent-Transcend Medical, Inc]	Aqueous Shunts and Stents for Glaucoma – Medicare Advantage
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: L39071, A58810 – Platelet Rich Plasma NGS: L38937, A58609 – Platelet Rich Plasma Noridian: None Novitas: L39068, A58808 – Platelet Rich Plasma Palmetto: None
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00438R Transcatheter Mitral Valve Repair (TMVR) (Mitral valve Transcatheter Edge-to- Edge Repair (TEER) is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g., thoracotomy, transapical)	NCD – CED (Coverage with Evidence Development) National Coverage Analysis Decision Memo: CAG-00438R Transcatheter Mitral Valve Repair (TMVR) (Mitral valve Transcatheter Edge-to- Edge Repair (TEER) is not covered for patients outside of a CMS-approved CED study. For additional information, see https://www.cms.gov/medicare/coverage/evidence

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	Optical Coherence Tomography (OCT) of the Middle Ear (e.g., PhotoniCare ClearView® System) – Medicare Advantage
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	Optical Coherence Tomography (OCT) of the Middle Ear (e.g., PhotoniCare ClearView® System) – Medicare Advantage
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	Orthopedic Applications of Stem-Cell Therapy (Including Autologous Stem Cells Used with Allografts and Bone Substitutes) – Medicare Advantage
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	Orthopedic Applications of Stem-Cell Therapy (Including Autologous Stem Cells Used with Allografts and Bone Substitutes) – Medicare Advantage
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	Ex Vivo Lung Perfusion (EVLV) – Medicare Advantage
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	Ex Vivo Lung Perfusion (EVLV) – Medicare Advantage
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including	Ex Vivo Lung Perfusion (EVLV) – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	
0507T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral (LipiFlow)	Thermal Treatments for Dry Eye Syndrome – Medicare Advantage
0509T	Electroretinography (ERG) with interpretation and report, pattern (pERG)	NCD: None LCD/LCA: See Below WPS: L37015, A57599 Visual Electrophysiology Testing CGS: L38992, A58706 Electroretinography (ERG) First Coast: L37398, A57644 Electroretinography (ERG) NGS: L36831, A57060 Visual Electrophysiology Testing Noridian: None Novitas: L37371, A56672 Electroretinography (ERG) Palmetto: None BCBSM/BCN: Electroretinography (ERG), Multifocal Electroretinography (mfERG) and Pattern Electroretinography (pERG) – Medicare Advantage
0510T	Removal of sinus tarsi implant	Subtalar Arthroereisis – Medicare Advantage
0511T	Removal and reinsertion of sinus tarsi implant	Subtalar Arthroereisis – Medicare Advantage
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	Extracorporeal Shock Wave Treatment of Wounds – Medicare Advantage
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	Extracorporeal Shock Wave Treatment of Wounds – Medicare Advantage
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	Treatment of Varicose Veins/Venous Insufficiency – Medicare Advantage
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	interpretation; complete system (electrode and implantable monitor)	CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the leads and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	NCD: None LCD/LCA: See Below WPS: L35490, A56902 – Category III Codes CGS: None First Coast: None NGS: None Noridian: None Novitas: None Palmetto: None
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	Transcatheter Mitral Valve Procedures – Medicare Advantage
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable	Transcatheter Mitral Valve Procedures – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	annulus reconstruction device, percutaneous approach including transseptal puncture	
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	Handheld Radiofrequency Spectroscopy and Computer-aided fluorescence imaging During Breast-Conserving Surgery (e.g., MarginProbe, LumiSystem) – Medicare Advantage
0553T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report	NCD: None LCD/LCA: See Below WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0554T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report	NCD: None LCD/LCA: See Below WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0555T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data	NCD: None LCD/LCA: See Below WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0556T	Bone strength and fracture risk using finite element analysis of functional data, and bone-	NCD: None LCD/LCA: See Below

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density	WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0557T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report	NCD: None LCD/LCA: See Below WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	NCD: None LCD/LCA: See Below WPS: None CGS: L36460, A57132 - Bone Mass Measurement First Coast: None NGS: None Noridian JE: None Noridian JF: None Novitas: None Palmetto: L39268, A59040 - Bone Mass Measurement
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	Thermal Treatments for Dry Eye Syndrome – Medicare Advantage
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	Orthopedic Applications of Stem-Cell Therapy (Including Autologous Stem Cells Used with Allografts and Bone Substitutes) – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	Orthopedic Applications of Stem-Cell Therapy (Including Autologous Stem Cells Used with Allografts and Bone Substitutes) – Medicare Advantage
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	NCD 20.38 – Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-Teer) NCA Decision Memo CAG-00468N - Tricuspid transcatheter edge-to-edge repair (T-TEER) is not covered for patients outside of a CMS-approved study.
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	NCD 20.38 – Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-Teer) NCA Decision Memo CAG-00468N - Tricuspid transcatheter edge-to-edge repair (T-TEER) is not covered for patients outside of a CMS-approved study.
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0572T	Insertion of substernal implantable defibrillator electrode	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0573T	Removal of substernal implantable defibrillator electrode	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0577T	Electrophysiological evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameter	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0578T	Interrogation device evaluation (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review and report by a physician or other qualified health care professional	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	Cryoablation of Tumors Located in the Kidney, Lung, Breast, Pancreas, or Bone – Medicare Advantage
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous	Focal Treatments for Prostate Cancer – Medicare Advantage
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	Focal Treatments for Prostate Cancer – Medicare Advantage
0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision, set-up and patient education on use of equipment [Home OCT (Notal Vision Ltd.)]	Home Monitoring Device for Age-Related Macular Degeneration – Medicare Advantage
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support, data analyses and	Home Monitoring Device for Age-Related Macular Degeneration – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	reports, with a minimum of 8 daily recordings, each 30 days	
0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	Home Monitoring Device for Age-Related Macular Degeneration – Medicare Advantage
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the outpatient Setting – Medicare Advantage
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the outpatient Setting – Medicare Advantage
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (i.e., lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	Magnetic Resonance Spectroscopy – Medicare Advantage
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	Magnetic Resonance Spectroscopy – Medicare Advantage
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of	Magnetic Resonance Spectroscopy – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	biomarker data for determination of relative chemical differences between discs	
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	Magnetic Resonance Spectroscopy – Medicare Advantage
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	Implantable Cardioverter Defibrillator (ICD), including Subcutaneous ICD And Substernal ICDs – Medicare Advantage
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: L38231, A56644 – Endovenous Stenting NGS: None Noridian JE: None Noridian JF: None Novitas: L37892, A56414 – Endovenous Stenting Palmetto: None
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	NCD: None LCD/LCA: See Below WPS: None CGS: L39958, A59880 Intervertebral Disc Repair First Coast: None NGS: None Noridian JE: L39960, A59882 Intervertebral Disc Repair Noridian JF: L39662, A59884 Intervertebral Disc Repair Novitas: None Palmetto: L39942, A59886 Intervertebral Disc Repair
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	NCD: None LCD/LCA: See Below WPS: None CGS: L39958, A59880 Intervertebral Disc Repair First Coast: None NGS: None Noridian JE: L39960, A59882 Intervertebral Disc Repair Noridian JF: L39662, A59884 Intervertebral Disc Repair Novitas: None

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		Palmetto: L39942, A59886 Intervertebral Disc Repair
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	NCD: None LCD/LCA: See Below WPS: None CGS: L39958, A59880 Intervertebral Disc Repair First Coast: None NGS: None Noridian JE: L39960, A59882 Intervertebral Disc Repair Noridian JF: L39662, A59884 Intervertebral Disc Repair Novitas: None Palmetto: L39942, A59886 Intervertebral Disc Repair
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	NCD: None LCD/LCA: See Below WPS: None CGS: L39958, A59880 Intervertebral Disc Repair First Coast: None NGS: None Noridian JE: L39960, A59882 Intervertebral Disc Repair Noridian JF: L39662, A59884 Intervertebral Disc Repair Novitas: None Palmetto: L39942, A59886 Intervertebral Disc Repair
0640T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	Near-Infrared Spectroscopy for Wound Examination – Medicare Advantage
0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	NCD 20.38 – Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-Teer) NCA Decision Memo CAG-00468N - Tricuspid transcatheter edge-to-edge repair (T-TEER) is not covered for patients outside of a CMS-approved study.
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	NCD: 100.1 Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity LCD/LCA: See Below

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		WPS: A54923 Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity CGS: None First Coast: L33411, A57145 Surgical Management of Morbid Obesity NGS: L35080, A56863 Select Minimally Invasive GERD Procedures Noridian JE: A53026 Billing and Coding: Bariatric Surgery Coverage Noridian JF: A53028 Billing and Coding: Bariatric Surgery Coverage Novitas: L35022, A56422 Bariatric Surgical Management of Morbid Obesity Palmetto: L34576, A56852 Laparoscopic Sleeve Gastrectomy for Severe Obesity
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session; single organ	Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease – Medicare Advantage
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure)	Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease – Medicare Advantage
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional (implantable loop recorders)	Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	Wireless Capsule Endoscopy for Gastrointestinal Disorders – Medicare Advantage
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging	Focal Treatments for Prostate Cancer – Medicare Advantage
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	Interventions for Juvenile and Adolescent Progressive Scoliosis – Medicare Advantage
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	Interventions for Juvenile and Adolescent Progressive Scoliosis – Medicare Advantage
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	Non-Covered Items and Services based on Statutory exclusions, not covered by any Medicare outpatient benefit category, not reasonable and necessary
0665T	Donor hysterectomy (including cold preservation); open, from living donor	Non-Covered Items and Services based on Statutory exclusions, not covered by any Medicare outpatient benefit category, not reasonable and necessary
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	Non-Covered Items and Services based on Statutory exclusions, not covered by any Medicare outpatient benefit category, not reasonable and necessary
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	Non-Covered Items and Services based on Statutory exclusions, not covered by any Medicare outpatient benefit category, not reasonable and necessary
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	Non-Covered Items and Services based on Statutory exclusions, not covered by any Medicare outpatient benefit category, not reasonable and necessary
0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more. [iStent Infinite]	Aqueous Shunts and Stents for Glaucoma – Medicare Advantage
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors – Medicare Advantage
0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	implantable pulse generator and diaphragmatic lead(s)(VisONE)	
0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure) (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure) (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s) (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	function, with connection to existing dual leads (VisONE)	
0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0683T	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function (VisONE)	NCD: 160.19 Phrenic Nerve Stimulator LCD/LCA: None
0707T	Injection(s), bone substitute material (e.g., calcium phosphate) into subchondral bone defect (i.e., bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	Subchondroplasty (Accufill) – Medicare Advantage
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	NCD: 100.7 – Colonic Irrigation LCD/LCA: None
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	Focal Treatments for Prostate Cancer – Medicare Advantage
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or	NCD: None LCD/LCA: See Below

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	WPS: None CGS: None First Coast: L38396/A56952 Cardiology Non-Emergent Outpatient Stress Test NGS: None Noridian: None Novitas: L35083/A56423 Cardiology Non-Emergent Outpatient Stress Test Palmetto: None
0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	Add-on Code; Code first: 88302 NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: None NGS: None Noridian: L35702, A56514 - Mohs Micrographic Surgery Novitas: None Palmetto: None
0752T	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	Add-on Code; Code first: 88304 NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: None NGS: None Noridian: L35702, A56514 - Mohs Micrographic Surgery Novitas: None Palmetto: None
0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	Add-on Code; Code first: 88305 NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: None NGS: None Noridian: L35702, A56514 - Mohs Micrographic Surgery Novitas: None

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		Palmetto: None
0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	Add-on Code; Code first: 88307 NCD: None LCD/LCA: See Below WPS: None CGS: None First Coast: None NGS: None Noridian: L35702, A56514 - Mohs Micrographic Surgery Novitas: None Palmetto: None
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	Transcutaneous Electrical Nerve STIMULATION (e.g., Cefaly®, eTNS, Axon) AND Transcutaneous Afferent Patterned Stimulation (e.g., Cala ONE™, Cala TRIO™ CALA kIQ) – Medicare Advantage
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	Transcutaneous Electrical Nerve STIMULATION (e.g., Cefaly®, eTNS, Axon) AND Transcutaneous Afferent Patterned Stimulation (e.g., Cala ONE™, Cala TRIO™ CALA kIQ) – Medicare Advantage
0780T	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract	Fecal Microbiota Transplantation (Fecal Bacteriotherapy) – Medicare Advantage
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	Bronchial Thermoplasty for the Treatment of Asthma – Medicare Advantage
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	Bronchial Thermoplasty for the Treatment of Asthma – Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	Interventions for Juvenile and Adolescent Progressive Scoliosis – Medicare Advantage
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemakers, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemakers, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial, and right ventricular pacemaker components)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound,	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0801T	Transcatheter removal and replacement of permanent dualchamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial, and right ventricular pacemaker components)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0802T	Transcatheter removal and replacement of permanent dual chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0803T	Transcatheter removal and replacement of permanent dualchamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dualchamber leadless pacemaker system)	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis,	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	NCD: 100.1 Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	Tibial Nerve Stimulation – Medicare Advantage
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial	Tibial Nerve Stimulation – Medicare Advantage
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	Tibial Nerve Stimulation – Medicare Advantage
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial	Tibial Nerve Stimulation – Medicare Advantage
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial,	NCD-CED: Coverage with Evidence Development

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
	including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	NCD-CED: Coverage with Evidence Development NCD: 20.8.4 – Leadless Pacemakers National Coverage Analysis (NCA) Decision Memo: CAG-00448N - Leadless pacemakers are non-covered when furnished outside of a CMS approved CED Study For additional information, see https://www.cms.gov/medicare/coverage/evidence
0859T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure)	Near-Infrared Spectroscopy for Wound Examination – Medicare Advantage
0860T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities	Near-Infrared Spectroscopy for Wound Examination – Medicare Advantage
0935T	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral	NCD-CED: Coverage with Evidence Development National Coverage Analysis (NCA) Decision Memo: CAG-00470N - Renal Denervation for Uncontrolled Hypertension

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
		Devices are non-covered when furnished outside of a CMS approved CED Study
0945T	Intraoperative assessment for abnormal (tumor) tissue, in-vivo, following partial mastectomy (e.g., lumpectomy) using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)	Handheld Radiofrequency Spectroscopy and Computer-aided fluorescence imaging During Breast-Conserving Surgery (e.g., MarginProbe, LumiSystem) – Medicare Advantage
0988T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous and subfascial [Intibia™ System]	Tibial Nerve Stimulation for Urinary and Fecal Incontinence – Medicare Advantage
0989T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous and subfascial [Intibia™ System]	Tibial Nerve Stimulation for Urinary and Fecal Incontinence – Medicare Advantage
0997T	Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location, dose, and intensity for magnetic stimulation therapy, derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram, including automated data processing, transmission, analysis, generation of treatment parameters with review, interpretation, and report	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders – Medicare Advantage
0998T	Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus, utilizing magnetic resonance imaging-based neuronavigation, with management, per day	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders – Medicare Advantage
1002T	Air displacement plethysmography, whole-body composition assessment, with interpretation and report	Methods To Measure Body Composition (e.g., DXA, BIA and ADP) - Medicare Advantage

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

To access CMS National and Local Determinations go to <https://www.cms.gov/medicare-coverage-database/search.aspx>

To access BCBSM/BCN medical policy, go to the BCBSM Medical Policy Router Search page at <https://www.bcbsm.com/providers/mpradmin/> and enter the policy name in the search box.

Codes	Description	Guidance
1019T	Lymph venous bypass, including robotic assistance, when performed, per extremity	Lymphedema-Surgical Treatments – Medicare Advantage

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

For the most up-to-date National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and CMS Manual System Transmittals, consult the Medicare Coverage Database at: <https://www.cms.gov/medicare-coverage-database/search.aspx>

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

For clinical decisions (except for durable medical equipment, DME), the Medicare Administrative Contractor (MAC) that has jurisdiction is determined by the place where the service is provided.

- Laboratory tests: The MAC's jurisdiction is based on the location of the reference laboratory that performs the test.
- Durable medical equipment (DME): The MAC's jurisdiction is based on the member's place of residence.
- Non-jurisdictional LCDs/LCAs: These documents cannot be used for a coverage determination unless the policy specifically lists them as internal coverage criteria.

Part A and Part B Medicare Administrative Contractor (MAC) Jurisdiction	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,

Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may be permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN's Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN's Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
12/26/2025	11/26/2025	Medicare Advantage policy established
06/20/2026	05/20/2026	Off-Cycle Review: Deleted the following codes: 0202T, 0266T-0273T, 0347T-0350T, 0394T, 0623T-0626T, 0662T, 0663T. Added the following codes: 0507T, 0988T, 0989T, 0997T, 0998T, 1002T, and 1019T. Update description of code 0600T.