# New and Emerging Technology - Coverage Status

| LOB(s): | State(s): |
|---|---|
| ☒ *Commercial*<br>☒ *Medicare* | ☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:* |
| ☒ *Medicaid* | ☒ *Oregon* |

## Enterprise Policy

*PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.*

*Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.*

## Background

New and emerging medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively "technologies") are often prescribed by physicians and/or marketed to the public before FDA or other government agency approval, or research is available in peer-reviewed literature documenting efficacy, safety, and long-term positive outcomes.

New and emerging technologies are reviewed by the New Technologies and Operational Criteria (NTOC) Committee which is chaired by a PacificSource Medical Director. The PacificSource Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services. Pharmaceuticals are reviewed by the PacificSource Pharmacy and Therapeutics (P&T) Committee.

The NTOC Committee bases its recommendation of coverage on review and evaluation of the following resources:

- Available peer-reviewed and evidenced-based literature
- Survey of standards of care and coverage
- Consultation with specialists and expert professionals
- PacificSource group and individual contracts
- Medicare and Medicaid requirements

This “New and Emerging Technologies – Coverage Status” policy outlines the evaluation process of new and emerging technology as well as coverage status of items considered experimental, investigational, or unproven.

## Procedure

### Commercial

**Evaluation Process**

The NTOC Committee reviews and evaluates new technology and new application of existing technology of medical and behavioral healthcare procedures and devices. NTOC Committee members represent key departments and stakeholders who have operational insight or responsibility for applying the criteria developed by the Committee. A PacificSource Medical Director chairs the NTOC Committee and ensures the Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services.

Agenda items for the NTOC Committee to review for coverage status are collected from multiple sources, which include, but are not limited to:

- New CPT or HCPCS codes
- New FDA approvals
- Provider inquiries
- Reports of new technology acquired by a community provider or anticipated to have widespread acceptance
- Utilization reviews and trends
- Vendor requests – vendor requests for reassessment of coverage position are limited to an annual review unless there is a change in FDA status or Hayes, Inc. rating

To inform its decision-making, the NTOC Committee reviews peer-reviewed and evidence-based information, which indicates if the technology is in general use or a community standard, is under continued scientific review (testing/research), is shown to have a demonstratable benefit, or is shown to be safe and efficacious). The reviews may consist of the following:

- Technology assessment consisting of:
    - Information from appropriate government regulatory bodies such as Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS)
        - FDA approval alone, is not a basis for coverage
    - Assessment of peer-reviewed literature and their conclusions concerning:
        - Effect of the technology on health outcomes, with emphasis on random controlled clinical trial outcomes
        - Evidence comparing new technology to established alternatives
        - Results attained outside of investigational settings, with emphasis on studies that were not underwritten by the manufacturer or other sponsor with financial interest in the service or technology

    - Reports on long-term studies indicating improved health outcomes and/or clinical trials in process or recruiting
- Information available from evidence-based resources may vary depending on treatment procedure or device. The evidenced-based resources, which rely on the judgment of experts, include the following resources (additional resources may be reviewed as necessary based on the technology being reviewed):
    - Agency for Healthcare Research and Quality (AHRQ)
    - Carelon Medical Benefits Management Clinical Guidelines, formerly AIM (AIM Specialty Health) Clinical Guidelines
    - Alliance of Community Health Plans (ACHP)
    - American College of Radiology® (ACR)
    - American Hospital Formulary Service Drug Information (AHFS® DI™)
    - Bree Collaborative – Foundation for Health Care Quality
    - Centers for Disease Control and Prevention (CDC)
    - Cochrane Collaboration
    - Facts and Comparison®
    - Hayes, Inc., and Hayes Genetic Testing Evaluation Service
    - MCG Health
    - MEDLINE® (component of PubMed®
    - Micromedex®
    - National Comprehensive Cancer Network® (NCCN)
    - National Institute for Health and Care Excellence (NICE)
    - Oregon Health Evidence Review Commission (HERC)
    - Professional Societies Recommendations and Practice Guidelines
    - UpToDate®
    - U.S. Pharmacopeia Dispensing Information
    - Washington Health Technology Assessment (HTA)
    - Washington Health Technology Clinical Committee (HTCC)
- Survey of similar market carriers and their published coverage position and/or medical policy concerning the service of technology under review
- PacificSource utilization and authorization data, as available and applicable

The PacificSource Medical Director may seek input or consult with specialists and professionals who have expertise in a specific technology when additional information is needed.

The NTOC committee, which includes a Medical Director, makes a determination based on the review of the technology that results in either:

- A covered service, which may include developing specific clinical guidelines criteria

- Experimental, Investigational, or Unproven (E/I/U) determination, which is added to the "New and Emerging Technologies – Coverage Status" policy or as an E/I/U item to an existing policy related to the technology reviewed
    - A technology may be indicated for archival (i.e., remains unproven and will not be reviewed annually unless upon request) when the following conditions are met:
        - The scientific evidence does not support clinical efficacy of the technology demonstrated by ONE of the following:
            - There is no general use within the medical community, i.e., the technology does not meet community standards
            - There have not been clinical studies for five or more years, indicating the technology is no longer under scientific review
            - The technology has not been proven to have a demonstratable benefit or been shown to be safe and efficacious
        - Claims utilization indicates PacificSource has not received a request for a period of at least two years
    - The unproven technology which has been determined to be archivable, will be moved to an excel sheet (NTOC Agenda Review Schedule) on the Special Function SharePoint site and noted as archived in the modification history along with associated codes

**Quality Oversight**

The "New and Emerging Technologies – Coverage Status" policy will be reviewed at least annually.

In addition, an annual report summarizing the NTOC review activity is presented to our Clinical Quality and Utilization Management (CQUM) committee, which consists of external providers and PacificSource Medical Directors, for review.

### Medicaid

PacificSource Community Solutions (PCS) follows Excluded Services Guidelines E1 and E2 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology.

### Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

## Experimental/Investigational/Unproven Determinations for Coverage Status

The new and emerging medical technologies in the following list have been determined by the NTOC Committee to be experimental, investigational, or unproven (E/I/U) and therefore are not covered. The impact of these technologies on health outcomes has not been established as the current scientific evidence is either not yet sufficient or does not support clinical efficacy.

The NTOC Committee has the authority to add new technologies or revise the determinations listed below based on additional review of current scientific evidence, advice, and recommendations by the NTOC Committee.

**Experimental/Investigational/Unproven Determinations for Coverage Status**

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **AcuDetox (Auricular Acupuncture) treatment Addiction/substance abuse disorder or any other indication.** | No Specific Code<br>97810, 97811 | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>(Refer to Contract for coverage as well) |
| **Allogeneic haemopoietic stem cell transplantation (HSCT) and Autologous stem cell transplant (AHSCT) for Crohn's Disease** | No Specific Code<br>38240 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Artificial Iris (Custom Flex) for the Treatment of Aniridia (e.g., Custom Flex Artificial Iris)** | C1839, 66999,<br>66683 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Bone Marrow Aspirate Concentrate (BMAC) therapy & Hematopoietic progenitor cell (HPC) used alone or in combination with other bone graft materials for all orthopedic applications including adjunct to spinal surgery** | 38220; 38230;<br>38232; 38240;<br>38241 | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>Exception: Bone Marrow Aspiration for transplant members |
| **Botox injections for Cricopharyngeal (CP) dysfunction** | No Specific Code<br>31571, 43499,<br>43236 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Ceramics/Calcium Bone Void Fillers (also known as synthetic bone void fillers); used alone or in combination with other bone graft materials or bone marrow aspirate for all indications** | No Specific Code<br>20900, 20902 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Chromoendoscopy (In vivo analysis), (also known as chromoscopy and chromocolonoscopy) for all indications,** | No Specific Code<br>44799, 45399,<br>45999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Clinicom" software platform for all indications** | No Specific Code<br>96146, 96127,<br>96130, 96136,<br>96138 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Coil embolization of hemorrhoids (Emborrhoid technique)** | No Specific Code<br>37241, 37244 | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **embolization of the hemorrhoidal arteries.** | | |
| **Continuous Passive Motion (CPM) for Knees and all other indications** | No Specific Code<br>E0935, E0936 | Not Covered (Experimental/Investigational/Unproven)<br><br>(Legacy Employee Health Plan covers for knees) |
| **Cryoablation for chronic rhinitis (allergic or nonallergic) (e.g., ClariFix device)** | No Specific Code<br>31243 | Not Covered (Experimental/Investigational/Unproven) |
| **Deep Brain Stimulation (e.g., Reclaim DBS) for Obsessive-compulsive disorder and comorbid psychiatric disorders.** | No specific Code<br>**CPT Codes:**<br>61863, 61864, 61867, 61868, 61880, 61850, 61860<br>**HCPC Codes:**<br>L8680, L8685, L8686, L8687, L8688 | Not Covered (Experimental/Investigational/Unproven) |
| **EarliPoint™ Evaluation - for diagnosing and assessing autism in children 16 to 30 months old** | No specific Code<br>97110, 97112 | Not Covered (Experimental/Investigational/Unproven) |
| **Erector Spinae Pain block (ESP block) for all indications** | No Specific Code<br>64999 | Not Covered (Experimental/Investigational/Unproven) |
| **External Trigeminal Nerve Stimulation (eTNS) System (e.g., Monarch) indication ADHD in children aged 7 to 12 years** | E0733, A4541 | Not Covered (Experimental/Investigational/Unproven) |
| **External upper limb tremor stimulator (e.g.; Cala One; Cala Trio) for essential tremors or Parkinson's Disease** | E0734; A4542 | Not Covered (Experimental/Investigational/Unproven) |
| **Extracorporeal shock wave therapy (ESWT) for all indications** | 28890 | Not Covered (Experimental/Investigational/Unproven) |
| **Gait Analysis (computerized) (Motion Analysis) for all indications.** | No Specific Code<br>96000, 96001, 96004 | Not Covered (Experimental/Investigational/Unproven) |
| **gammaCore Sapphire handheld device (non-invasive Vagus nerve stimulation (nVNS)) for migraines; cluster headaches and Paroxysmal Hemicrania** | E0735 | Not Covered (Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Ganglion Impar block for Coccydynia, pelvic pain, and all other indications** | No Specific Code<br>64999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Genicular artery embolization (GAE) (embolization of the knee) – treatment of osteoarthritis (OA) or other degenerative conditions** | No Specific Code<br>37242, 20999 | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>**Approved** for coverage of knee hemarthrosis |
| **GI Effects Comprehensive Profile by Genova Diagnostics analyzes biomarkers for all indications** | No Specific Code<br>81599, 89240 | Not Covered<br>(Experimental/investigational/Unproven) |
| **Implantable intracardiac pressure monitors (e.g., CardioMEMS™ Heart Failure (HF) System) all indications** | No Specific Code<br>93264, 33289, C2624 | Not Covered<br>(Experimental/investigational/Unproven) |
| **Intense Pulse Light (IPL)Therapy for the treatment of dry eyes from meibomian gland dysfunction** | No Specific Code<br>17999 | Not Covered<br>(Experimental/investigational/Unproven) |
| **Interactive Metronome Training (e.g., attention deficit hyperactivity disorder or any other indication)** | No Specific Code<br>97039, 97139, 97799<br>**Therapy codes:**<br>97110, 97112 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Interferential Current Stimulation Therapy (IFS/ICT) (electrical stimulation) for all indications.** | No Specific Code<br>S8130, S8131 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Intra-arterial Infusion (Embolization) of imipenem/cilastatin sodium (IPM/CS) refractory interphalangeal (DIP) joint-Osteoarthritis (OA) and all other indications** | No Specific Code<br>37242, 20999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Intravascular Lithotripsy (IVL) – (Shockwave intravascular lithotripsy system (IVL)) Coronary** | 92972 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **iovera System ("cryoneurolysis,"-cold ) for Knee Osteoarthritis or all indications** | C9809, 64624, 64640 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Jaw Motion Rehab System (e.g., TheraBite Jaw Motion Rehabilitation System, OraStretch** | E1700, E1701, E1702 | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **press, and Dynasplint Trismus System) – all indications** | | |
| **LimFlow System for Transcatheter Arterialization of Deep Veins (TADV) for all indications** | 0620T, C1889 | Not Covered (Experimental/Investigational/Unproven) |
| **LipiView II and LipiScan Ocular Surface Interferometer images with Dynamic Meibomian Imaging (DMI)** | No Specific Code 92285 | Not Covered (Experimental/Investigational/Unproven) |
| **Lymphaticovenous Anastomosis (LVA) (Lymphovenous bypass or shunt) for lymphedema** | No Specific Code 38999, 38308 | Not Covered (Experimental/Investigational/Unproven) |
| **Magnetic Resonance Neurography (MRN), (also known as Magnetic Resonance Neurogram or MR Imaging of the Peripheral Nerves (PNI)) for all indications** | No Specific Code 76498 | Not Covered (Experimental/Investigation/Unproven) |
| **Mesenchymal Stem Cell Therapy - considers the use of mesenchymal stem cell therapy (e.g., AlloStem, Osteocel, Trinity Evolution) for all orthopedic applications including repair or regeneration of musculoskeletal tissue, osteochondritis dissecans, spinal fusion, and bone nonunions.** | No Specific Code 20999 | Not Covered (Experimental/Investigational/Unproven) |
| **Metatarsophalangeal Joint Replacement Implants: (Bioabsorbable; Ceramic prostheses (e.g., Moje), Modular implants (e.g., Cartiva), biologic spacers (e.g., InterPhlex implant)) for all indications and second Metatarsophalangeal joint replacement** | L8641, L8642, L8658; L8699, 28899 | Not Covered (Experimental/Investigational/Unproven) |
| **MiraDry System aka Microwave or electromagnetic energy (microwave thermolysis) for all indications of hyperhidrosis** | No Specific Code 17999 | Not Covered (Experimental/Investigational/Unproven) |
| **Navigated transcranial magnetic stimulation (nTMS) - presurgical planning** | No Specific Code 64999 | Not covered (Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Nd: YAG laser vitreolysis (YAG Reflex Laser Systems, Ellex) - treatment of vitreous floaters or any other indication** | No Specific Code<br>67031, 67299 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Nerve Hydrodissection procedure (e.g.; Tarsal Tunnel tibial nerve compression) for all other indications** | No Specific Code<br>28899, 28035, 64999, 64722, 76942 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Non-Pneumatic Active Dynamic Compression (NPCD) or Garment to treat conditions like lymphedema; venous insufficiency or wound healing** | No Specific Code<br>E0677, E0678, E0679, E0680, E0681, E0682 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Occipital Nerve Stimulation (ONS) - intended to prevent migraines headaches and all other headaches** | No Specific Code<br>64553, 61885, 61886 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Occipital Nerve Decompression Surgery (ONS) (Also known as Peripheral Occipital nerve decompression surgery or migraine surgery) for Migraine Headaches or any other indication** | No Specific Code<br>64640, 64716, 64722, 64999, | Not Covered<br>(Experimental/Investigational/Unproven)<br>. |
| **Oscillation and lung expansion device (e.g., BiWave Clear System) for all indications** | No Specific Code<br>E1399, E0469, A7021 | Not Covered<br>(Experimental/Investigation/Unproven)<br><br>**Note**: Volara System FDA recall 7/16/2024. |
| **OSSIOfiber Trimmable Nail System/Compression Screws - Orthopedic Surgeries fixation devices for all indications.** | No Specific Code<br>L8699 | Not Covered<br>(Experimental/Investigation/Unproven)<br><br>**(May be included in surgical procedure)** |
| **Ovarian or Internal Iliac Vein Embolization for Treatment of Pelvic Congestion Syndrome** | No Specific Code<br>37241 | Not Covered<br>(Experimental/Investigational/unproven) |
| **Platelet Rich Plasma for all indications (e.g., platelet-enriched plasma, platelet-rich concentrate) for all indications** | 0232T, P9020, G0460, G0465 | Not Covered<br>(Experimental/Investigational/unproven) |
| **Patency Capsule Testing (e.g., PillCam Patency System, Agile** | No specific code,<br>91299 | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Patency System/Capsule) for all indications** | | |
| **Percutaneous electrical nerve stimulation (PENS)/percutaneous neuromodulation therapy (PNT) all indications (e.g., chronic musculoskeletal or neuropathic pain)** | No Specific Code<br>64999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Percutaneous Needled Tenotomy (PNT) for all indications** | No Specific Code<br>27599, 20599; | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)** | 92972 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **PortableConnect/ROMTech (ROMTech Portable Connect Rehab Adaptive Device) (e.g., postsurgical rehabilitative exercises) for all indications** | No Specific Code<br>E1399 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Prescription Digital Therapeutics (PDT) (prescription-only software to manage medical disorders or diseases)** | No Specific Code<br>T1505, A9291, A9292 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Pudendal Nerve Blocks (Injections) ( e.g., Chronic Pelvic Pain, Pudendal neuralgia (PN) and all other indication)** | No Specific Code<br>64430 | Not Covered<br>(Experimental/Investigation/Unproven)<br><br>**Note:** Does not apply to the use of pudendal nerve blocks in obstetrics and other operative pelvic procedures; |
| **Pulsed radiofrequency Denervation (for the treatment of various chronic pain syndromes) for all indications** | No Specific Code<br>64999 | Not Covered<br>(Experimental/Investigation/Unproven) |
| **Radiofrequency Ablation (RFA) For Treatment Of Cervicogenic Headache** | No Specific Code<br>64640 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Radiofrequency ablation (RFA) of Cluneal Nerve for all indications** | No Specific Code<br>64640 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Radiofrequency ablation (RFA) of the femoral and obturator nerves for all indications** | No Specific Code<br>64640 | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Radiofrequency Ablation – Genicular nerve ablation (knee pain) for all indications** | 64624 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency Neurotomy for Morton's Neuroma** | 64632, 64640 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency Ablation for Pudendal Nerve pain (pelvic pain, Pudendal Neuralgia or any other indication)** | No Specific Code<br>64630 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency Nasal Valve w/VivAer Device – Treatment of nasal airway obstruction** | 30469 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency Neurotomy for planter nerve pain (also known as plantar neuropathy, (e.g., Baxter's Neuritis)or Tarsal Tunnel Syndrome for all indications** | 64632, 64640 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency ablation (RFA) for Plantar fasciitis (plantar fasciosis) (heel pain syndrome)** | 64640 | Not Covered (Experimental/Investigational/Unproven) |
| **Reflectance confocal microscopy (RCM) (Confocal laser scanning microscopy) for skin lesion surveillance** | No Specific Code<br>96931, 96932, 96933, 96934, 96935, 96936 | Not Covered (Experimental/Investigational/Unproven) |
| **Renal sympathetic denervation for all indications** | No Specific Code<br>0338T, 0339T, 0935T | Not Covered (Experimental/Investigational/Unproven) |
| **Reverse Axillary Lymphatic Mapping - all indications** | No Specific Code<br>38999, 38900 | Not Covered (Experimental/Investigational/Unproven) |
| **RhinAer Procedure non-invasive treatment for chronic rhinitis (allergic or nonallergic)** | No Specific Code<br>31242 | Not Covered (Experimental/Investigational/Unproven |
| **Robotic Assisted In-Home Therapy Device/ Systems (e.g., Motus Hand/Foot Robotic System, IpsilHand) for all indications** | E0739, E0738 | Not Covered (Experimental/Investigational/Unproven) |
| **Selective Myectomy for all indications** | No Specific Code<br>21499 | Not Covered (Experimental/Investigational/Unproven) |
| **Sphenopalatine Ganglion Nerve (SPG) Block for any indication including, but may not be limited to, headaches or trigeminal neuralgia** | 64505 | Not Covered (Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Supraorbital Nerve Block Injection w/Ultrasound (SON) - for all indications (e.g., Migraine Headaches; Cluster Headache suboccipital neuralgia)** | No Specific Code<br>64400 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **TenoTac® Soft Tissue Fixation System for all indications** | No Specific Code<br>28285 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Topaz Coblation Therapy, (also known as Topaz Surgery, Radiofrequency coblation tenotomy) for all indications** | No Specific Code<br>28899, 20999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Trabecular Bone Score (TBS) Bone Mineral Density Measurement to Predict Fracture Risk in Postmenopausal Patients or any other condition** | 77089, 77090,<br>77091, 77092 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Transcutaneous Vagal Nerve Stimulator (t-VNS) (e.g., noninvasive VNS (nVNS) treatment resistive depression, Bipolar or psychological disorders and all other indications** | E0735 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Trigeminal nerve blocks for Trigeminal Neuralgia; Cluster Headaches, Migraines and other facial pain** | No Specific Code<br>64400 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Vascular Lymph Node Transfer (VLNT) also called lymph node transfer (LNT); Lymphatic By-pass Procedure) for all indications** | No Specific Code<br>38999, 38308 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Vertebral axial decompression (non-surgical, noninvasive spinal traction therapy) for any indication** | S9090 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Virtual Reality Cognitive Behavioral Health therapy device** | E1905 | Not Covered<br>(Experimental/Investigational/Unproven)<br><br>**(All "T" code related to Virtual Reality denied per Category III Policy)** |
| **Whole body vibration (WBV) therapy (e.g.; Galileo Plate Device) for all indications** | No Specific Code<br>97110 97112<br>97139 97530<br>E1399 | Not Covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT HCPCS | COVERAGE STATUS |
|---|---|---|
| **Wireless GI Motility Monitoring Capsule Testing (e.g., SmartPill Mobility Testing System) – for all indications** | 91112 | Not Covered (Experimental/Investigational/Unproven) |



## Definitions

**Experimental, Investigational, or Unproven** - medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively "technologies") where peer-reviewed and evidence-based literature indicates the technology remains under scientific review, is not in general use or a community standard, has not been found to be safe and efficacious, and has not been shown to have a demonstratable benefit.

## Related Policies

Category III Current Procedural Terminology (CPT) Codes

Medical Necessity Reviews

Proprietary Laboratory Codes (PLA)

## Appendix

**Policy Number:**

**Effective:** 1/1/2021 **Next review:** 2/1/2026

**Policy type:** Enterprise

**Author(s):**

**Depts.:** Health Services

**Applicable regulation(s):** Social Security Act Section §1862(a), 42 CFR 411.15(o), NCQA UM 10(A)(B) – Evaluation of New Technology; Excluded Services Guideline E1 and E2 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology; OAR 410-120-1200; WAC 284-44-043, WAC 284-46-507, IDS 41-3930, 41-5903, MCA 33-32-103, ARM 37.82.102(c).

**Commercial OPs:** 7/2025

**Government OPs:** 7/2025