



New and Emerging Technologies - Coverage Status

State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:	LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid
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Enterprise Policy

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 determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. 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.

NTOC bases its recommendation of coverage on review and evaluation of available peer-reviewed, evidenced-based literature, survey of standards of care and coverage, consultation with specialists and expert professionals, and PacificSource group and individual contracts.

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 investigational not elsewhere categorized.

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 NTOC and ensures a behavioral healthcare professional is involved in the decision-making process for behavioral healthcare services.

Agenda items for NTOC 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, NTOC consults with specialists and professionals who have expertise in the technology under review and reviews peer-reviewed, evidence-based information:

- Technology assessment consisting of:
 - Information from appropriate government regulatory bodies such as Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS)
 - 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
 - Report on long term studies indicating improved health outcomes and clinical trials now recruiting or in process
- Information available from evidence-based resources; examples include but are not limited to:
 - Agency for Healthcare Research and Quality (AHRQ)
 - American College of Radiology® (ACR)
 - American Hospital Formulary Service Drug Information (AHFS® DI™)
 - 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)
 - Oregon Health Evidence Review Commission (HERC)
 - U.S. Pharmacopeia Dispensing Information
 - 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
- Utilization and authorization data, as available and applicable

The PacificSource Medical Director may seek input from relevant specialists and professionals who have expertise in the technology when additional information is needed.

The determination of the technology under review by the NTOC committee results in one of three options:

- Covered without requiring authorization;
- Covered based on specific clinical guideline criteria; or
- Deemed investigational and added to the “New and Emerging Technologies – Coverage Status” policy or as an investigational item to an existing policy related to the technology reviewed

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, for review.

Coverage Status

The following are new and emerging medical technologies that are considered **investigational**, and therefore are not covered, because the current scientific evidence is not yet sufficient to establish the impact of these technologies on health outcomes.

Our Medicaid and Medicare plans use this policy as a resource to determine coverage when there are no Medicaid or Medicare Coverage criteria guidelines (e.g. Medicaid defined criteria or NCD/LCD).

Procedure: Health Services

COVERAGE STATUS TABLE:

PROCEDURE	CPT HCPCS	COVERAGE STATUS
3D-Printed Orthopedic Implants (Additive Manufacturing) for all orthopedic indications	No Specific Code, 0559T, 0560T, 0561T 0562T L8699	Not Covered (Experimental/Investigational/Unproven)
Ablation, Pulmonary Tumor(s) Cryoablation	0340T	Not covered (Experimental/Investigational/Unproven).
Actigraphy Testing, recording, analysis, interpretation & report	95803	Not covered (Experimental/Investigational/Unproven).
Alair Bronchial Thermoplasty System (Asthmatx, Inc.)	31660, 31661	Not covered (Experimental/Investigational/Unproven).
ALCAT Food Intolerance Test	No specific 83516	Not covered (Experimental/Investigational/Unproven).
Alpha2 Macroglobulin (A2M)/Alpha 2 Macroglobulin Human Plasma (platelet poor plasma)	No specific code S2150	Not covered (Experimental/Investigational/Unproven).
AlphaStim (cranial electrotherapy stimulation)	No specific code: E1399, K1002	Not covered (Experimental/Investigational/Unproven).
Annulotomy (coblation assisted microdiscectomy, Arthrocare plasma disc decompression (PDD))	62287	Code is not specific to annulotomy. Requires Preauthorization

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Artificial Retina	0100T, C1841, C1842, L8608	Not covered (Experimental/Investigational/Unproven).
AspirinWorks® Test	84431	Not covered (Experimental/Investigational/Unproven).
Athletic Pubalgia (Sports Hernia) Surgery (open or laparoscopic)	No specific code	Not covered (Experimental/Investigational/Unproven).
Autologous Tears for dry eye conditions	No specific code	Not covered (Experimental/Investigational/Unproven).
Auricular Electro-acupuncture (Auricle Electro-acupuncture or Pulsed Stimulation)	No Specific Code S8930	Not Covered (Experimental/Investigational/Unproven)
Automated Percutaneous Lumbar Discectomy (APLD) or Automated Percutaneous Mechanical Lumbar Discectomy (Stryker Dekompressor™ or ArthroCare Spine Wand)	No specific code 62287	Not covered (Experimental/Investigational/Unproven).
Automatic Nerve Conduction Studies/Noninvasive Nerve Conduction Testing	95905 or non-specific code 95999	Not covered (Experimental/Investigational/Unproven).
Avance Nerve Graft (nerve allograft)	64910, 64912, 64913	Not covered (Experimental/Investigational/Unproven).
Balloon Dilation of Eustachian Tube	No specific code 69799 C9745	Not covered (Experimental/Investigational/Unproven).
Baroreflex Stimulation Devices Therapy (Baroreflex Activation Therapy or BaroStim Neo System)	0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T	Not covered (Experimental/Investigational/Unproven).
Biacuplasty of the spine (e.g. Bialys TransDiscal System)	No specific code: 22899	Not covered (Experimental/Investigational/Unproven).
Bioelectrical Impedance Analysis (BIA)Spectroscopy/ BioSpectroscopy (BIS)	No Specific Code 93702, 0358T	Not covered (Experimental/Investigational/Unproven).
Blood Brain Barrier Disruption (BBBD) for the treatment of Central Nervous System (CNS) tumors	No specific code 96549	Not covered (Experimental/Investigational/Unproven).
Bone Marrow Aspirate Concentrate for Ankle Arthrodesis and Lower Extremity Bone Nonunion	No specific codes 38220 38232	Not covered (Experimental/Investigational/Unproven).
Brachytherapy, Electronic for all indications	0394T, 0395T	Not covered (Experimental/Investigational/Unproven).
Breast Thermography	No specific code 93740	Not covered (Experimental/Investigational/Unproven).
Breath Test for Heart Transplant Rejection (Heartsbreath test)	0085T	Not covered (Experimental/Investigational/Unproven).
CardioMEMS™ HF System	Non-specific codes C9741 C2624 93799	Not covered (Experimental/Investigational/Unproven).
Carotid intima-media thickness (IMT)	0126T and 93895	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Cartiva Synthetic Cartilage Implant (SCI)	No specific code C1763 L8641 L8642 L8658 28291	Not covered (Experimental/Investigational/Unproven).
Chelation therapy	M0300	Requires preauthorization. Reviewed on a case-by-case basis.
Cold Caps (scalp hypothermia)	No specific code E1399, A9273	Not covered (Experimental/Investigational/Unproven).
Comprehensive Arthroscopic Management (CAM) for the Shoulder	No specific code 29999	Not covered (Experimental/Investigational/Unproven).
Compression Garment for Trunk (i.e. Bellise Bra (JoViPak) or Tribute vest (Solaris) for lymphedema)	No specific code: E1399	Not covered (Experimental/Investigational/Unproven).
Computed Tomography (CT) of the Knee for pre-operative mapping or planning	No specific code: 73700 - 73702	Not covered (Experimental/Investigational/Unproven). Except for Legacy Employee Health Plan (LEHP) for Makoplasty
Computerized thermal imaging (temperature gradient studies) (e.g., cephalic thermogram; peripheral thermogram)	93740	(Experimental/Investigational/Unproven). except for certain specialized breast diagnostics
Continuous Passive Motion (CPM) for Knees and all other joint	E0936 E0935	Not covered (Experimental/Investigational/Unproven) (Except for LEHP)
Corneal Hysteresis	92145	Not covered (Experimental/Investigational/Unproven).
Craniotherapy/ Craniosacral therapy	No specific code: 97799	Not covered (Experimental/Investigational/Unproven).
CxBladder Detect	No specific code 81479	Not covered (Experimental/Investigational/Unproven).
CyPass Microstent	0474T	Not covered (Experimental/Investigational/Unproven).
Digital Motion X-ray (DMX)	76496, 76120, 76125	Not covered (Experimental/Investigational/Unproven).
Disposable Negative Pressure Wound Therapy systems (e.g. SNaP, PICO, VACVia Prevena)	97607, 97608, G0456, G0457	Not covered (Experimental/Investigational/Unproven) (Inpatient post-op use requires a claims review)
Dorsal Root Ganglion (DRG) Stimulator	no specific code L8680, 63650, 63685	Not covered (Experimental/Investigational/Unproven)
Dry Needling	No specific code: 20560, 20561	Not covered (Experimental/Investigational/Unproven).
Electron Beam Tomography (EBT)	S8092	Not covered (Experimental/Investigational/Unproven).
Electrocardiogram (ECG) signal analysis technologies	0206T and 31626, 93278	Not covered (Experimental/Investigational/Unproven).
Electromagnetic Navigational Bronchoscopy	31626 31627	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Endothelial Function Assessment Non-invasive	0337T	Not covered (Experimental/Investigational/Unproven).
Epidural Adhesiolysis (Racz procedure)	62263, 62264	Not covered (Experimental/Investigational/Unproven).
Extra Corporeal Shock Wave Therapy (ESWT) for musculoskeletal conditions	No specific code, 0101T, 0102T, 0512T, 0513T 28890	Not covered (Experimental/Investigational/Unproven).
Extra-osseous Subtalar Joint Implant for Talotarsal Stabilization (HyProCure®)	0335T	Not covered (Experimental/Investigational/Unproven).
Factors 7, 8 and 9 in Disseminated Intravascular Coagulation (DIC) – Not hemophilic	No specific code	Not covered (Experimental/Investigational/Unproven).
Fenestrated AAA endovascular stent graft	34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 34839	Not covered (Experimental/Investigational/Unproven). not covering the endovascular stent
Fibrospect/Actifest	No specific code 83520, 83883, 84999	Not covered (Experimental/Investigational/Unproven).
Fractional Laser Treatment (Carbon Dioxide (CO2) and ER: YAG excessive scarring removal	No Specific Code 0479T 0480T	Not Cover (Experimental/Investigational/Unproven)
Focused Ultrasound for treatment of uterine fibroids	0071T - 0072T	Not covered (Experimental/Investigational/Unproven).
Galectin-3 testing (BG Medicine, Inc.)	82777	Not covered (Experimental/Investigational/Unproven).
High Intensity Focused Ultrasound (HIFU)	No Specific Code 55880 55899	Not covered (Experimental/Investigational/Unproven) (covered only for radiation therapy recurrence for prostate cancer)
Hip Orthosis (post-op)	L1685, L1686	Not covered (Experimental/Investigational/Unproven).
Hydrogen Breath Test for Irritable Bowel Syndrome	No specific code 82491 91065	Not covered (Experimental/Investigational/Unproven).
Intradiscal Electrothermal Therapy (IDET)	22526-22527	Not covered (Experimental/Investigational/Unproven).
Interactive Metronome Training	No Specific Code 97110 97112	Not Covered (Experimental/Investigational/Unproven)
Interferential Muscle Stimulators	E0740, E1399, S8130, S8131	Not covered (Experimental/Investigational/Unproven).
Internal Neurolysis “nerve brushing or combing”	No specific code 64727, 69990	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Intracapt Intraosseous Nerve Ablation	No Specific Code 22899, C9752 C9753 64999	Not covered (Experimental/Investigational/Unproven).
Intra-vascular Optical coherence tomography (OCT) for Cardiac (intracoronary OCT)	No Specific Code 92978, 92979, 37252, 37253, C1753	Not Covered (Experimental/Investigational/Unproven)
Iontophoresis for home use	No specific code E1399	Not covered (Experimental/Investigational/Unproven)
Jaw Motion Rehab System--(e.g., TheraBite Jaw Motion Rehabilitation System, OraStretch press, and Dynasplint Trismus System)	E1700, E1701, E1702	Not Covered Experimental/Investigational/Unproven)
Ketamine for use in depression, bipolar disorder and migraine headache		Not covered (Experimental/Investigational/Unproven)
Kotler Airway Valve	No specific code 30999	Not covered (Experimental/Investigational/Unproven).
Laparoscopic Ultrasound-Guided Radiofrequency Ablation (The Acessa System)	No Specific Code 0336T	Not covered (Experimental/Investigational/Unproven).
Laser Interstitial Thermal Therapy (LITT) also known as Cold Laser Therapy	No specific code: 19499, 32999, 47399, 48999, 53899, 55899, 60699, 64999	Not covered (Experimental/Investigational/Unproven) Except for Visualase for medically refractory seizures
Latera Nasal Implant	No Specific code E1399 30999 30468	Not Covered (Experimental, Investigational/Unproven)
Lightwave Therapy (Low Level Laser and Light Emitting Diode) (LLLT)	No specific code: E1399, S8948, 0552T	Not covered (Experimental/Investigational/Unproven). (covered for cancer related oral mucositis)
LINX Reflux Management System (Magnetic Sphincter Augmentation)	43284, 43285, 43289, C9737	Not covered (Experimental/Investigational/Unproven).
Lipiflow Thermal Pulsation and Lipiview Ocular Surface Interferometer (TearScience Inc.)	0207T and 0330T	Not covered (Experimental/Investigational/Unproven).
LipiView II Dynamic Meibomian Imaging (DMI)	No specific code 92285, 92499	Not covered (Experimental/Investigational/Unproven).
MAGec (magnetic expansion control system) Growth Rod	No specific code 22899	Not covered (Experimental/Investigational/Unproven).
Micro-Current Nerve Therapy (Stimulator) (MET) Devices	No Specific Code 64555	Not covered (Experimental/Investigational/Unproven)
Micronized Dehydrated Human/Chorion Membrane (dHCAM) injectable for plantar fasciitis	No specific code J3590	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Monarch External Trigeminal Nerve Stimulation (eTNS) System for ADHD	K1016 K1017	Not Covered (Experimental/Investigational/Unproven)
Mist Therapy®, Celleration MIST Therapy®, AR1000 Ultrasonic Wound Therapy System, AS1000 Ultrasound Wound Therapy System, The Qoustic Wound Therapy System, Jetox™ ND DeRoyal®, Misonix SonicOne Plus Ultrasonic Wound Care System, SonicOne® Ultrasound for wound healing	97610	Not covered (Experimental/Investigational/Unproven).
Monochromatic infrared energy (MIRE) (Anodyne Therapy System but not limited to)	No Specific Code 97026 97799 A4639 E0221	Not Covered (Experimental/Investigational/Unproven)
MRI full body scan	No specific code: 76498	Not covered (Experimental/Investigational/Unproven).
MRI of the Knee for pre-operative mapping or planning	No specific code: 76376, 76377, 73721, 73722, 73723	Not covered (Experimental/Investigational/Unproven). Except for Legacy Employee Health plan (LEHP) for Makoplasty
MRI/TRUS fusion biopsy of prostate (e.g. BioJet)	72195, 72196, 72197	Not covered (Experimental/Investigational/Unproven).
Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis (e.g. OneSwab, Quest SureSwab, BD Max vaginitis Test, NuSwab)	No Specific Code-81513, 81514, 87481, 87482, 87511, 87512, 87661, 87801, 87640, 87653, 87798, 87799, 87999	Not Covered (Experimental/Investigational/Unproven) (PacificSource covers screening for chlamydia and gonorrhea 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 87800)
Naltrexone (Vivitrol) Abdominal implants	No specific code A4550, J2315, J3490	Not covered (Experimental/Investigational/Unproven).
Navigated Transcranial Magnetic Stimulation (n-TMS)	0310T	Not covered (Experimental/Investigational/Unproven).
Nerve Integrity Monitoring (NIM Medtronic), Intraoperative Nerve Monitoring –endotracheal tube for any indication	No specific code 95920, 95937, 95940, 95941, G0453	Not covered (Experimental/Investigational/Unproven).
Network Spinal Analysis	No specific codes 97139	Not covered (Experimental/Investigational/Unproven).
Neutralizing Antibody Testing in Multiple Sclerosis	No specific codes: 87253, 86382, 86384	Not covered (Experimental/Investigational/Unproven).
Occipital Nerve Decompression Surgery for Migraine Headaches	No specific Code 64640 64716 64722 64732 64999	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Oral Appliance: Nociceptive Trigeminal Inhibition Tension Suppression System for migraine.	No Specific Code	Not covered (Experimental/Investigational/Unproven).
Oral Cancer Screening Systems	No specific code: 40899, 41599, 41899	Not covered (Experimental/Investigational/Unproven).
OrthoFlo (MiMedx) Amniotic Fluid derived product for injection	No Specific Code Q4139	Not covered (Experimental/Investigational/Unproven).
OsteoAMP	No specific codes	Not covered (Experimental/Investigational/Unproven).
OVA1™ test for ovarian cancer	No specific code: 84999	Not covered (Experimental/Investigational/Unproven).
Patency Capsule Testing	No specific code, 91299	Not covered (Experimental/Investigational/Unproven).
Patient Specific Instrumentation (PSI) for joint arthroplasty including preoperative imaging, cutting guides and custom implants	No specific codes	Not covered (Experimental/Investigational/Unproven).
Percutaneous Discectomy using the Stryker Dekompressor™ or ArthroCare Spine Wand™	62287	Code is not specific, Requires Preauthorization
Percutaneous Electrical Nerve Stimulation, aka Percutaneous Neuromodulation Therapy (PENS/PNT)	No specific code E1399, 64999	Not covered (Experimental/Investigational/Unproven).
Phenol Neurolysis of Interspinous Ligaments T5-6, T6-7 and T7-8	No specific code 22899	Not covered (Experimental/Investigational/Unproven).
Photodynamic Therapy for (stage I or II) Head and Neck Cancer	No specific code 96567	Not covered (Experimental/Investigational/Unproven).
Phrenic Nerve Stimulation for Central Sleep Apnea (CSA)	No specific code 64575	Not covered (Experimental/Investigational/Unproven).
Placental alpha microglobulin-1 (AmniSure) rapid slide test for presence of amniotic fluid	84112	Not covered (Experimental/Investigational/Unproven).
Posterior intrafacet implant	0219T- 0222T	Not covered (Experimental/Investigational/Unproven).
Posterior Nasal Neurectomy (PNN)	No specific code 30999, 31231	Not covered (Experimental/Investigational/Unproven).
Pregnancy Ultrasound (3D) or (4D) dimensional	No specific code: 76376, 76377, 76499	Not covered (Experimental/Investigational/Unproven).
Presacral Neurectomy	No specific code: 64999 58999	Not covered (Experimental/Investigational/Unproven).
PRODENSE injectable regenerative graft	No specific code 20900	Not covered (Experimental/Investigational/Unproven).
Prolotherapy(Proliferation Therapy)	M0076	Not covered (Experimental/Investigational/Unproven).
Prostatic arterial embolization (transcatheter embolization)	No specific 37243	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Pulsed electromagnetic stimulation (aka OrthoCor Active Knee System) or target Pulsed Electromagnetic field therapy (tPEMF)	No Specific Code E0761	Not Covered (Experimental/Investigation/Unproven)
Quantitative Pupillometry	0341T	Not covered (Experimental/Investigational/Unproven).
Quantitative Sensory Testing (QST)	0106T, 0107T, 0108T, 0109T, 0110T	Not covered (Experimental/Investigational/Unproven).
Radiofrequency Thermocoagulation (RFTC) Thoracic Interspinous Ligament	No specific code 22899	Not covered (Experimental/Investigational/Unproven).
Remote Retinal Optical Coherence Tomography (Notal Vision)	0604T, 0605T, 0606T	Not Covered (Experimental/Investigational/Unproven)
RESPeRate breathing device	No specific code: E1399	Not covered (Experimental/Investigational/Unproven)
Saliva and Urine Hormone testing	No specific code (uses same code as serum) HCPC S3650	Not covered (Experimental/Investigational/Unproven).
Scintimammography (may also be called nuclear breast imaging or “mira luna”, or Breast Specific Gamma Imaging)	No specific codes 78800, 78801, 78803, 78804 S8080	Not covered (Experimental/Investigational/Unproven) for all groups except LEHP.
ScoliScore (Axial Biotech Inc.) multigene test	0004M	Not Covered (Experimental/Investigational/Unproven).
Scrambler Therapy/Calmare Therapy Device (Transcutaneous Electrical Modulation Pain Processing (TEMPRA))	0278T	Not covered (Experimental/Investigational/Unproven).
ShuntCheck®	No specific code 62252	Not covered (Experimental/Investigational/Unproven).
SilverHawk Plaque Excision System (FoxHollow Technologies, Inc.) for peripheral vascular disease	No specific code: 37799	Not covered (Experimental/Investigational/Unproven).
SofPulse (Ivivi Health Services) pulsed electromagnetic therapy	E0761	Not covered (Experimental/Investigational/Unproven).
Sphenopalatine Ganglion Block for Migraine	No specific code, 64999, 64505	Not covered (Experimental/Investigational/Unproven).
SpineJack System	No specific code, 22513, 22514, 22515	Not covered (Experimental/Investigational/Unproven).
Stem Cell Therapy for Peripheral Artery Disease (i.e., SmartPREP , Fibrinet)	0263T, 0264T, 0265T	Not covered (Experimental/Investigational/Unproven).
Stimulan (off label use for antibiotic administration)	No specific code C1713, C1763	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Subchondroplasty (SCP)for knee (calcium phosphate synthetic bone-void filler)	No specific code 27599	Not covered (Experimental/Investigational/Unproven).
Suction Assisted Protein Lipectomy	15877, 15878, 15879, 15830	Not covered (Experimental/Investigational/Unproven).
Surface electromyography (SEMG; Myovision – chiropractic technique that applies surface electrodes to skin which record a specific muscle or muscle group’s electrical potential.)	S3900, 96002, 96003, 96004 or nonspecific codes 95999, 97799, 99199	Not covered (Experimental/Investigational/Unproven).
Surgisis Anorectal Fistula Plug(AFP)	46707	Not Covered (Experimental/Investigational/Unproven)
Tenex Health TX System (percutaneous ultrasonic ablation)	No specific code 17999, 20999, 25999	Not covered (Experimental/Investigational/Unproven).
Therapeutic Apheresis with Selective HDL Delipidation and Plasma Reinfusion	0342T	Not covered (Experimental/Investigational/Unproven).
Thermal Shrinkage Therapy (used for tendons and ligaments)	No Specific Code 28999	Not covered (Experimental/Investigational/Unproven).
Transcatheter Renal Sympathetic Denervation unilateral or bilateral	0338T, 0339T	Not covered (Experimental/Investigational/Unproven).
Transcutaneous pulsed electrical joint stimulation (BioniCare Bio 1000 System)	E0762	Covered only for osteoarthritis; Not covered for other conditions (Experimental/Investigational/Unproven).
Transcutaneous Vagal Nerve Stimulator (t-VNS) and Vagus Nerve Stimulation for Depression/Bipolar	No specific code 64568 64569 64570 C1767 L8680 E1399	Not covered (Experimental/Investigational/Unproven).
Transoral Incisionless Fundoplication (TIF) (i.e. EsophyX Stretta or MUSE™)	43210 43257	Not covered (Experimental/Investigational/Unproven).
Treace Lapiplasty Bunion System	No specific code, 28297 L8699	Not covered (Experimental/Investigational/Unproven).
Vascular Lymph Node Transfer (VLNT)	No specific code 38999	Not covered (Experimental/Investigational/Unproven).
Vertebral Artery Angioplasty and/or Stenting	No Specific Code 0075T, 0076T (code not specific to vertebral artery)	Not covered (Experimental/Investigational/Unproven).
Vertebral axial decompression (Lordex; VAX-D; DRX at Back-2-Backs clinic, Med-X, and IDD (Internal disc decompression therapy)	S9090	Not covered (Experimental/Investigational/Unproven).
ViviGen Cellular Bone Matrix	No specific code	Not covered (Experimental/Investigational/Unproven).

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Whole Body Hyperthermia for Cancer	No specific codes 77605 or 77620	Not covered (Experimental/Investigational/Unproven).
Wireless GI Motility Capsule Testing (e.g. SmartPill)	No specific code 91112	Not covered (Experimental/Investigational/Unproven).

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NTOC has decision authority for new technologies and may revise the “Coverage Status Table” in the New and Emerging Technologies Administrative procedure based on the research, advice and recommendations of the Committee.

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2021

Next review: 1/1/2022

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): N/A

Commercial Ops: 6/2021

Government Ops: 6/2021