# New and Emerging Technology - Coverage Status

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

## 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 determinations 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 experimental/investigational and/or unproven not elsewhere categorized.

New or updated guidelines and resources will be added, as appropriate, when new product lines added).

## 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 NTOC 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 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 may vary depending on treatment procedure or device. The evidence-based resources may include, but are not limited to the following:
  - Agency for Healthcare Research and Quality (AHRQ)
  - 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;
- Utilization and authorization data, as available and applicable.

The PacificSource Medical Director may seek input from 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;
- 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.

## Medicaid

### Oregon

PacificSource Community Solutions (PCS) follows Guideline Notes 172 and 173 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology. In the absence of OHP guidance, PCS will follow this policy.

## Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS criteria, evidence-based criteria, and internal policy guidelines, requests are reviewed on an individual basis for determination of coverage and medical necessity.

## Experimental/Investigational/Unproven Determinations for Coverage Status

The following list of new and emerging medical technologies have been determined by the NTOC Committee to be considered experimental, investigational, and/or unproven and therefore are not covered, because the current scientific evidence is not yet sufficient to establish the impact of these technologies on health outcomes.

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 Table**

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 HCPCS | COVERAGE STATUS |
|---|---|---|
| **ALCAT Food Intolerance Test (Antigen Leukocyte Antibody Test; Cytotoxic Food Test; Automated Food Allergy Test)** | No Specific Code<br>83516 | Not covered (Experimental/Investigational/Unproven). |
| **Alpha2 Macroglobulin (A2M)/Alpha 2 Macroglobulin Human Plasma (osteoarthritis and other painful orthopedic conditions)** | No Specific Code<br>S2150 | Not covered (Experimental/Investigational/Unproven). |
| **AlphaStim (cranial electrotherapy stimulation)** | E1399, K1002 | Not covered (Experimental/Investigational/Unproven). |
| **Artificial Retina Prosthesis Device (Electronic Retinal Prosthesis)** | 0100T, 0472T 0473T C1841, C1842, L8608 | Not covered (Experimental/Investigational/Unproven). |
| **Athletic Pubalgia (Gilmore's Groin Sports/Sportsman's Hernia, Occult Hernia) (open or laparoscopic)** | No Specific Code<br>49999 49659 | Not covered (Experimental/Investigational/Unproven) |
| **Arthroflex Graft (Arthrex) (AFlex Graft)-Amnion Matrix/Viscous (e.g. Shoulder Surgery or soft tissue repair)** | No Specific Code<br>29999 Q4125 | Not covered<br>(Experimental/Investigational/Unproven)<br><br>May be listed with procedure |
| **Autologous adipose-derived regenerative cell therapy (ADRC) for all indications** | 0489T 0490T 0565T 0566T 27599 | Not Covered<br>(Experimental/investigational/unproven) |
| **Autologous Tears for treatment of dry eye disease** | No specific code<br>68899 | Not covered (Experimental/Investigational/Unproven). |
| **Auricular Electro-acupuncture (Auricle Electro-acupuncture or Auricle Pulsed Stimulation) (acupuncture points on the ear)** | S8930 | Not covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT HCPCS | COVERAGE STATUS |
|---|---|---|
| **Automated Percutaneous Lumbar Discectomy (APLD) or Automated Percutaneous Mechanical Lumbar Discectomy (e.g. Stryker Dekompressor™ or ArthroCare Spine Wand)** | 0274T 0275 62287 62380 | Not covered (Experimental/Investigational/Unproven). |
| **Automated Point-of-Care Nerve Conduction Studies (automated nerve conduction studies)** | No Specific Code<br>95905 95999 G0255 | Not covered (Experimental/Investigational/Unproven). |
| **Avance Nerve Graft (human nerve allograft) surgical repair of peripheral nerve** | 64910, 64911 64912, 64913 | Not covered (Experimental/Investigational/Unproven). |
| **Axillary Reverse Lymphatic Mapping (ARM) for Lymphatic drainage** | No Specific Code<br>38999 | Not covered<br>(Experimental/Investigation/Unproven) |
| **Baroreflex Hypertension Therapy System (BAT) or BaroStim Neo System** | 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T C1825 | Not covered (Experimental/Investigational/Unproven). |
| **Biodesign Otologic Skin Graft Repair (Porcine Graft) for Otologic procedures** | No Specific Code<br>21235, 15275, C1763, Q4100 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Bioelectrical Impedance Analysis (BIA)/ Bio Spectroscopy (BIS) (diagnose/monitor lymphedema)** | 93702 | Not covered (Experimental/Investigational/Unproven) |
| **Blood Brain Barrier Disruption (BBBD) for the treatment of Central Nervous System (CNS) tumors** | No Specific Code<br>96549 64999 | Not covered (Experimental/Investigational/Unproven)<br><br>(May be under Unlisted Chemotherapy code) |
| **Bone (Calcaneal) Marrow Aspirate Concentrate (e.g. Ankle arthrodesis, Nonunion bones, jaw surgery, all other indications)** | No Specific Code<br>38232 20999 | Not covered (Experimental/Investigational/Unproven). |
| **Brachytherapy, Electronic (EBT)for all indications (included but not limited to: AXXENT Electronic Brachytherapy, INTRABEAM (EBT) SYSTEM, ESTEYA (EBT)System)** | 0394T, 0395T | Not covered (Experimental/Investigational/Unproven). |
| **Breath Test for Heart Transplant Rejection (Heartsbreath test)** | 0085T | Not covered (Experimental/Investigational/Unproven). |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Bronchial Thermoplasty (BT) (e.g. Alair; Asthmatrix Inc) Asthma treatment and other respiratory indication** | 31660 31661 | Not covered<br>(Experimental/Investigational/Unproven) |
| **CardioMEMS™ HF System (CM) (Implantable Pulmonary Artery Pressure Sensor-device-PAP) (Implanted Hemodynamic Monitor (IHN)-CM-IHM)** | 33289 93264<br>93799 C2624<br>C9741 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Carotid intima-media thickness (Ultrasound) (IMT)** | 93998 93799 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Cold Caps/Scalp Cooling Devices and Caps for chemotherapy-induced Alopecia (CIA)** | 0662T, 0663T<br>E1399, A9273 | Not covered<br>(Experimental/Investigational/Unproven).<br>(May be request under A9273 Wigs any type) |
| **Comprehensive Arthroscopic Management (CAM) for Shoulder (minimally invasive surgical procedure)** | No specific code<br>29999 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Compression Garment for Trunk for lymphedema** | No specific code<br>E1399 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Computerized thermal imaging (temperature gradient studies) (e.g., cephalic thermogram; peripheral thermogram)** | 93740 | Not Covered<br>(Experimental/Investigational/Unproven). |
| **Continuous Passive Motion (CPM) for Knees and all other joint** | E0935 E0936 | Not covered<br>(Experimental/Investigational/Unproven)<br><br>(Legacy Employee Health Plan covers for knees) |
| **Corneal Hysteresis (CH) (e.g. Ocular Response Analyzer G3) Diagnosis/management of glaucoma** | 92145 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Coronary Intravascular Lithoplasty (IVL) (e.g., Shockwave Intravascular Lithotripsy System)** | C1761 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Cryosurgical Tool for Chronic Rhinitis (e.g., ClariFix)** | No Specific Code<br>C9771 30999 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Craniotherapy/ Craniosacral therapy (CST) - (a noninvasive osteopathic technique) – all indications** | No Specific Code<br>97799 | Not covered<br>(Experimental/Investigational/Unproven). |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Digital Infrared radiation (Breast Thermography, Thermogram, Temperature Gradients Studies) (e.g., screening for breast cancer screening, multiple diagnosis)** | No Specific Code<br>93740, 93799 | Not covered<br>(Experimental/investigational/Unproven) |
| **DISC Nucleoplasty (Percutaneous Disc Decompression (PDD) or Radiofrequency Coblation) (e.g., ArthroCare System, Pre-D SpineWand)** | No Specific Code<br>62287 S2348 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Dry Needling for trigger points for the treatment of myofascial trigger points and all other indications** | 20560, 20561 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Electrocardiogram (ECG) signal analysis technologies (Multifunction Cardiogram) (e.g., Premier Heart's MCG System or 3D MP)** | No Specific Code<br>93278 93799 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Endothelial Function Assessment Non-invasive (e.g., EndoPAT 2000) (Peripheral Arterial Tonometry (PAT))** | No Specific Code<br>93998 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Extra Corporeal Shock Wave Therapy (ESWT) for musculoskeletal conditions** | 0101T, 0102T<br>0512T 0513T<br>28890 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Extra-osseous Subtalar Joint Implant for Talotarsal Stabilization (EOTTS) (Subtalar Arthroereisis) (Multiple Implants)** | 0335T 0510T<br>0511T 28899<br>S2117 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Factors 7, 8 and 9 in Disseminated Intravascular Coagulation (DIC) – Not hemophilic** | 85230 85240<br>85250 | Not covered<br>(Experimental/Investigational/Unproven). |
| **Flower AmnioFlo Injections –all indications** | Q4177 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Fractional Laser Treatment (Carbon Dioxide (CO2) and ER: YAG excessive scarring removal** | 0479T 0480T | Not covered<br>(Experimental/Investigational/Unproven) |
| **Geniculate artery embolization (GAE) (embolization of the knee) – Long term pain relief with Osteoarthritis** | No Specific Code<br>37244 | Not covered<br>(Experimental/Investigational/Unproven) |
| **High Intensity Focused Ultrasound (HIFU) Any other indication including as an initial treatment for localized prostate cancer.** | 55880 55899<br>C9734 0071T<br>0072T | Not covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Hydrogen Breath Test/Methane Breath Test for Gastrointestinal Disorders** | 91065 | Not covered (Experimental/Investigational/Unproven). |
| **Intradiscal Biacuplasty (IDB) or Biacuplasty (Percutaneous Annuloplasty) (e.g., Baylis System) referred to as (TIPs)** | No Specific Code<br>22899 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Intradiscal Electrothermal Therapy (IDET) (Thermal Intradiscal Procedure (TIP))** | 22526-22527 | Not covered (Experimental/Investigational/Unproven). |
| **Interactive Metronome Training (e.g., attention deficit hyperactivity disorder or any other indication)** | No Specific Code<br>97110 97112 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Interferential Current Stimulation Therapy for Pain (IFS)** | E1399, S8130, S8131 | Not covered (Experimental/Investigational/Unproven). |
| **Internal Neurolysis “nerve brushing or combing” –all indications** | No Specific Code<br>64727, 69990 | Not covered (Experimental/Investigational/Unproven). |
| **Interphalangeal Joint implants/ metatarsophalangeal joint implants (e.g., Integra Silicone Implant, Swanson, Cartiva Implant, Primus)** | No Specific Code<br>28291 L8641 L8642 L8658 L8699 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Intra-vascular Optical coherence tomography (OCT) Imaging of Coronary arteries (intracoronary OCT)** | No Specific Code<br>92978, 92979 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Iontophoresis (Home Use) for Hyperhidrosis (axillae, palms, or soles)** | 97033 | Not covered (Experimental/Investigational/Unproven) |
| **Jaw Motion Rehab System--(e.g., TheraBite Jaw Motion Rehabilitation System, OraStretch press, and Dynasplint Trismus System) – all indications** | E1700, E1701, E1702 | Not covered<br>Experimental/Investigational/Unproven) |
| **Kotler Airway Nasal Valve – (Airway only) - functioning nasal airway valve post-op** | No Specific Code<br>30999 | Not covered (Experimental/Investigational/Unproven). |
| **Lapiplasty 3D Bunion Correction (Treace Medical Bunion System) (new approach to Lapidus Bunionectomy)** | No Specific Code<br>28297 28740 C1713 | Not Covered<br>(Experimental/Investigational/Unproven) |
| **Laser Interstitial Thermal Therapy (LITT) – (Magnetic resonance imaging (MRI)-guided laser** | 61738 61736 64999 | Not covered (Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **ablation) (MRI-guided laser interstitial thermal therapy (MRgLITT)-all indication except epileptic seizures** | | (Exception – see criteria Visualase Laser Thermal Therapy for Epileptic Seizures) |
| **Latera Nasal Implant for all indications** | 30999 30468 31299 | Not covered<br>(Experimental, Investigational/Unproven) |
| **LINX Reflux Management System (Magnetic Sphincter Augmentation)** | 43284, 43285, 43289 | Not covered (Experimental/Investigational/Unproven). |
| **LipiFlow Thermal Pulsation System (TearScience Inc.) Eyelid Thermal Pulsation Therapy- (also called vectored thermal pulsation (VTP)) for Dry Eye Syndrome** | 0207T | Not covered (Experimental/Investigational/Unproven). |
| **LipiView II Ocular Surface Interferometer Images with Dynamic Meibomian Imaging (DMI) (Tear Science) (Tear film imaging)** | 0330T 0507T 92285 92499 | Not covered (Experimental/Investigational/Unproven). |
| **Lipoprotein, direct measurement, small dense LDL cholesterol (sdLDL-c)** | 83722 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Lymphaticovenous Anastomosis (LVA) (Lymphovenous bypass or shunt) for lymphedema** | No Specific Code<br>38999 38308 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Magnetic Resonance Neurography (MRN), (also known as Magnetic Resonance Neurogram or MR Imaging of the Peripheral Nerves (PNI))** | No Specific Code<br>76498 | Not covered<br>(Experimental/Investigation/Unproven)<br><br>(AIM does not review) |
| **MAGnetic Expansion control Growing Rods (MaGEC Rods) for scoliosis** | No specific code 22899 | Not covered (Experimental/Investigational/Unproven). |
| **Micro-Current Nerve Therapy (Stimulator) (MET) Devices (e.g., micro electrical therapy (MET) or micro electrical neurostimulation)** | 64555 | Not covered<br>(Experimental/Investigational/Unproven)<br><br>(May available over the counter without a prescription refer to contract language for over-the-counter) |
| **MicroGen DX qPCR & NGS Test (MicroGenDX) (test for bacterial/fungi Infection)** | 0112U | Not covered<br>(Experimental/investigational/unproven) |
| **MiraDry Microwave System (aka Microwave or electromagnetic** | No Specific Code<br>17999 | Not covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **energy (microwave thermolysis) for all indications of hyperhidrosis** | | |
| **Monarch External Trigeminal Nerve Stimulation (eTNS) System for ADHD in children 7-12 y/o** | K1016 K1017 | Not covered (Experimental/Investigational/Unproven) |
| **Mist Therapy® System for wound care— (Noncontact, low-frequency ultrasound debridement device)** | 97610 | Not covered (Experimental/Investigational/Unproven). |
| **Monochromatic infrared energy (MIRE) (Anodyne Therapy System but not limited to) – (Infrared heating pad system, also known as a monochromatic infrared energy (MIRE) device)** | 97026 A4639 E0221 | Not covered (Experimental/Investigational/Unproven) |
| **Multitarget Polymerase Chain Reaction (PCR) Testing for Bacterial vaginitis/vaginosis (Only)** | 81513, 81514 | Not covered (Experimental/Investigational/Unproven) |
| **NavDx TTMV HPV Blood Test (detects HPV associated cancer)** | No Specific Code 81479 | Not covered (Experimental/Investigational/Unproven) |
| **Navigated Transcranial Magnetic Stimulation (nTMS) (Nexstim) Navigated transcranial magnetic stimulation (nTMS) presurgical planning** | No Specific Code<br>64999 | Not covered (Experimental/Investigational/Unproven). |
| **Nociceptive Trigeminal Inhibition Tension Suppression System-(NTI-TSS or NTI-tension suppression system) for Headaches and Migraines** | No Specific Code21110, D7880 D8210 | Not covered (Experimental/Investigational/Unproven) |
| **Occipital Nerve Stimulation – Headaches or Occipital Neuralgia** | No Specific Code<br>64999<br>**Providers may use** 64553 or 64555 | Not covered (Experimental/Investigational/Unproven) |
| **Occipital Nerve Decompression Surgery for Migraine Headaches (Peripheral Occipital nerve decompression surgery or migraine surgery)** | No Specific Code<br>64716 64722 64732 64999 | Not covered (Experimental/Investigational/Unproven). |
| **OSSIOfiber Trimmable Nail System/Compression Screws - Orthopedic Surgeries fixation devices** | No Specific Code<br>L8699<br>(May be included in | Not covered (Experimental/Investigation/Unproven) |

| PROCEDURE | CPT HCPCS | COVERAGE STATUS |
|---|---|---|
| | surgical procedure) | |
| **Ovarian or Internal Vein Embolization (e.g., Pelvic Congestion Syndrome, pelvic pain)** | No Specific Code<br>37241 | Not covered<br>(Experimental/Investigational/unproven) |
| **Patency Capsule Testing** | No specific code, 91299 | Not covered (Experimental/Investigational/Unproven) |
| **Percutaneous Needled Tenotomy (PNT) (Percutaneous Tenotomy, Percutaneous Fasciotomy) with or without Tenex Procedure for all indications** | No Specific Code<br>27599 20999 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Percutaneous epidural adhesiolysis (RACZ Procedure) (Lysis of Epidural Adhesions) (e.g., treatment chronic back pain)** | 62263 62264 | Not covered<br>(Experimental/investigational/unproven) |
| **Percutaneous electrical nerve stimulation (PENS)/percutaneous neuromodulation therapy (PNT) all indications (e.g., chronic musculoskeletal or neuropathic pain)** | No specific code E1399, 64999 | Not covered (Experimental/Investigational/Unproven). |
| **Perineural Injection Therapy (PIT or Lyfgogt Therapy) (Perineural Subcutaneous Injection (PSI) and Perineural Deep Injection (PDI)) for all indications** | No Specific Code<br>Possible 20553 64445 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Phenol Neurolysis Injection (Chemical (Ablation) neurolysis) of Interspinous Ligaments (e.g. Prolotherapy when phenol used as a Sclerosing agent)** | No specific code 22899 62281 M0076 | Not covered (Experimental/Investigational/Unproven). |
| **Phrenic Nerve Stimulation (Diaphragm Pacing) for Central Sleep Apnea (CSA)** | 64575 64590 64580 64999 | Not covered (Experimental/Investigational/Unproven). |
| **Platelet-rich Plasma for all indications ((i.e., Aurix aka AutoloGel)** | 0232T G0460 P9020 | Not covered<br>(Experimental/Investigational/Unproven |
| **Posterior intrafacet implant (Allograft Dowel) - alternative technique to surgical fusion** | 0219T 0220T 0221T 0222T | Not covered (Experimental/Investigational/Unproven). |
| **Posterior Nasal Neurectomy (PNN) (e.g., severe allergic rhinitis)** | 30999, 31231 | Not covered (Experimental/Investigational/Unproven). |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
|---|---|---|
| **Pregnancy Ultrasound (Four-dimensional (4D) or (5D) five-dimensional imaging** | No Specific Code 76499 | Not covered (Experimental/Investigational/Unproven)<br>(**Refer to 3D imaging policy** for CPT Codes 76376 – 76377 for 3D imaging coverage criteria) |
| **Presacral Neurectomy (pelvic Denervation Procedure) (uses Laser, open and laparoscopic)** | No specific code: 58578 64999 58999 | Not covered (Experimental/Investigational/Unproven). |
| **Prescription Digital Therapeutics (PDT) (prescription-only software to manage medical disorders or diseases)** | No Specific Code<br>99199 E1399 T1505 A9291 A9999 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Prolotherapy (Proliferation Therapy) for all indications including musculoskeletal pain** | M0076 | Not covered (Experimental/Investigational/Unproven). |
| **Pulsed electromagnetic stimulation (PEMF)/ Target Pulsed Electromagnetic field therapy (tPEMF)/ Electrical Magnetic Therapy (e.g., OthroCor Active Knee System, SoftPulse Device)** | E0761 | Not covered<br>(Experimental/Investigation/Unproven) |
| **Quantitative Sensory Testing (QST) System for neurologic damage or disease** | 0106T, 0107T, 0108T, 0109T, 0110T | Not covered (Experimental/Investigational/Unproven). |
| **Radiofrequency Nasal Valve w/VivAer Procedure** | No Specific Code<br>30999 30801 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Radiofrequency of Benign thyroid nodule** | 60699 0673T | Not covered<br>(Experimental/investigational/unproven) |
| **Radiofrequency of the peripheral nerves innervating Hip region (Femoral and obturator nerves)** | No Specific Code<br>64640 | Not Covered (Experimental/Investigational/Unproven) |
| **Radiofrequency Thermocoagulation (RFTC) aka Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)** | 22526 22527 | Not covered (Experimental/Investigational/Unproven). |
| **Regeneten Bioinductive Implant (RegenePro) for all indications** | No Specific Code<br>15777 29827 29999 | Not covered<br>(Experimental/Investigational/Unproven) |
| **Remote Retinal Optical Coherence Tomography (Notal Vision home based) used to diagnose and** | 0604T, 0605T, 0606T | Not covered<br>(Experimental/Investigational/Unproven) |

| PROCEDURE | CPT<br>HCPCS | COVERAGE STATUS |
| --- | --- | --- |
| **monitor conditions that affect the retina** | | |
| **RESPeRate portable electronic breathing device (Biofeedback Device) to reduce Hypertension** | No specific code: E1399 | Not covered (Experimental/Investigational/Unproven)<br><br>(May be contract exclusion for Biofeedback) |
| **Saliva and Urine Hormone testing** | No specific code S3650 | Not covered (Experimental/Investigational/Unproven). |
| **Schroth Method Therapy (Resistive Exercise) (Scoliosis Curvature Correction)** | No Specific Code | Not covered (Experimental/Investigational/Unproven) |
| **Scintimammography (may also be called nuclear breast imaging or "mira luna", or Breast Specific Gamma Imaging)** | 78195 78800, 78801, 78803, 78804 S8080 | Not covered (Experimental/Investigational/Unproven) |
| **ShuntCheck®** | 62252 | Not covered (Experimental/Investigational/Unproven). |
| **SofPulse pulsed electromagnetic therapy (tPEMF) (Shortwave Diathermy device)** | No Specific Code<br>E0761 | Not covered (Experimental/Investigational/Unproven). |
| **Sphenopalatine Ganglion Block for Migraine** | 64999, 64505 64400 | Not covered (Experimental/Investigational/Unproven). |
| **SpineJack Expansion Kit (Implantable Fracture Reduction System) (Mechanical Vertebral Augmentation Device)** | 22513, 22514, 22515 0220T 0201T C1062 | Not covered (Experimental/Investigational/Unproven). |
| **Stellate Ganglion Nerve Block for Severe Stress/Posttraumatic Stress Disorder (PTSD)** | 64510 | Not covered (Experimental/Investigational/Unproven |
| **Stem Cell Therapy for Peripheral Artery Disease (PAD)** | 0263T, 0264T, 0265T | Not covered (Experimental/Investigational/Unproven). |
| **Stimulan Bone Void Filler (Stimulan Rapid Cure, Stimulan Bullet Mat, Stimulan Kits) (Calcium Sulfate Antibiotic carrier) for all indications.** | C1713 | Not covered (Experimental/Investigational/Unproven). |
| **Subchondroplasty (SCP) (calcium phosphate synthetic bone-void filler) - bone marrow lesions (BMLs) or bone marrow edema (BMEs) (e.g., knee)** | No specific code 27599 0707T | Not covered (Experimental/Investigational/Unproven). |

| PROCEDURE | CPT HCPCS | COVERAGE STATUS |
|---|---|---|
| **Sublingual (Liquid) Immunotherapy for Allergy treatment (SLIT, Liquid Allergy drops under tongue)** | No Specific Code 95199 | Not Covered (Experimental/Investigational/Unproven) (Pharmacy does not review) |
| **Supraorbital Nerve Block Injection w/Ultrasound (SON) – for all indication (e.g., Migraine Headaches suboccipital neuralgia)** | 64400 76942 | Not covered (Experimental/Investigational/Unproven) |
| **Surface electromyography (SEMG) (Myovision; Insight Discovery) (also known as surface scanning EMG) to assess muscle function** | S3900, 96002, 96003, 96004 | Not covered (Experimental/Investigational/Unproven). |
| **Thermography - (Digital Infrared radiation, Thermogram, Temperature Gradients Studies) (e.g., screening for breast cancer screening, multiple diagnosis)** | No Specific Code 93740 93799 | Not Covered (Experimental/Investigational/Unproven) |
| **Therapeutic Apheresis with Selective HDL Delipidation and Plasma Reinfusion** | 0342T | Not covered (Experimental/Investigational/Unproven). |
| **Thermal Capsular Shrinkage Therapy (Thermal capsulorrhaphy or Electrothermal Shrinkage) - used for tendons and ligaments of Synovial joint** | No Specific Code 28999 S2300 | Not covered (Experimental/Investigational/Unproven). |
| **Transcatheter Renal Sympathetic Denervation unilateral or bilateral (RFA of renal sympathetic nerves) for Resistant hypertension** | 0338T, 0339T | Not covered (Experimental/Investigational/Unproven). |
| **Transcervical Uterine Fibroid Ablation w/US guidance radiofrequency (T-RFA)** | 0404T | Not Covered (Experimental/Investigational/Unproven) |
| **Transcutaneous Electrical Modulation Pain Reprocessing (TEMPRA) e.g., Scambler Therapy/Calmare Therapy device** | 0278T | Not covered (Experimental/Investigational/Unproven) |
| **Transcutaneous pulsed electrical joint stimulation (BioniCare Bio 1000 System)** | E0762 | Not covered (Experimental/Investigational/Unproven) (**Exception** only covered for osteoarthritis) |
| **Transcutaneous Vagal Nerve Stimulator (t-VNS) and Vagus Nerve Stimulation (non-implantable) (e.g.,** | 64568 64569 64570 | Not covered (Experimental/Investigational/Unproven). |

| PROCEDURE | CPT HCPCS | COVERAGE STATUS |
|---|---|---|
| **Depression/Bipolar/psychological disorders)** | | |
| **Transoral Incisionless Fundoplication (TIF) (i.e., EsophyX Stretta or MUSE) – all indications** | No Specific Code<br>43210 43499 43257 | Not covered (Experimental/Investigational/Unproven). |
| **Vagus Nerve Stimulation (Non-implantable, noninvasive tVNS, gammaCore (nVNS)) for cluster and migraine headaches (e.g., gamma Sapphire)** | No Specific Code<br>E1399 K1020 | Not covered<br>(Experimental/Investigation/Unproven) |
| **Vascular Lymph Node Transfer (VLNT) (also called lymph node transfer (LNT) Lymphatic By-pass Procedure)** | 38999 38308 | Not covered (Experimental/Investigational/Unproven). |
| **Vertebral Artery Angioplasty and/or Stenting** | No Specific Code | Not covered (Experimental/Investigational/Unproven). |
| **Vertebral axial decompression (e.g. Lordex; VAX-D; DRX, and DRS System) (mechanized spinal distraction therapy or non-surgical traction device) for back pain** | S9090 | Not covered (Experimental/Investigational/Unproven). |
| **Wireless GI Motility Capsule Testing (e.g., SmartPill Mobility Testing System)** | 91112 | Not covered (Experimental/Investigational/Unproven). |

* HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS). CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

## Appendix

**Policy Number:**

**Effective:** 1/1/2021 **Next review:** 2/1/2023

**Policy type:** Enterprise

**Author(s):**

**Depts.:** Health Services

**Applicable regulation(s):** NCQA UM 10(A)(B) – Evaluation of New Technology ; Guideline Notes 172 and 173 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology; WAC 284-44-043, WAC 284-46-507, IDS 41-3930, 41-5903, MCA 33-32-1003, ARM 37.382.102

**Commercial OPs:** 7/2022

**Government OPs:** 7/2022