Category III CPT Codes

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Coverage Rationale

Overview

The American Medical Association (AMA) develops temporary Current Procedural Terminology (CPT) Category III codes to track the utilization of emerging technologies, services, and procedures. The Category III CPT code description does not establish a service or procedure as safe, effective, or applicable to the clinical practice of medicine.

Section 1862(a)(1)(A) of the Social Security Act (SSA) is the basis for denying payment for types of care, items, services, and procedures, not excluded by any other statutory clause while meeting all technical requirements for coverage, that are determined to be any of the following:

- Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used;
- Not proven to be safe and effective based on peer review or scientific literature;
- Experimental;
- Not reasonable and necessary for a particular patient;
- Furnished at a level, duration, or frequency that is not appropriate;
- Not furnished in accordance with accepted standards of medical practice; or
- Not furnished in a setting appropriate to the patient's medical needs and condition.

Items and services must be established as safe and effective to be considered reasonable and necessary. That is, the items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment; and
- Necessary for, and consistent with, generally accepted professional medical standards of care (e.g., not experimental); and
- Not furnished primarily for the convenience of the patient, the provider or supplier; and
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational and are not considered reasonable and necessary under SSA 1862(a)(1)(A). Medicare payment, therefore, may not be made for procedures performed using devices that have not been approved for marketing by the FDA unless performed in an approved FDA Investigational Device Exemption (IDE) trial.

This UnitedHealthcare Medicare Advantage Medical Policy is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Medical Policies that include category III codes.

For coverage guidelines for items and services **not** listed in this policy, first search the Medicare Coverage Database to confirm no applicable Medicare coverage guidelines exist. After searching the Medicare Coverage Database, if no National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) is found,

then search for a UnitedHealthcare Medicare Advantage Medical Policy that specifically addresses the service/code. If none is found, refer to the table below.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	No	**First Coast** L34859 (A57123) **Novitas**** L35081 (A54095)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	No	**First Coast** L34859 (A57123) **Novitas**** L35081 (A54095)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	No	**First Coast** L34859 (A57123) **Novitas**** L35081 (A54095)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	No	**First Coast** L34859 (A57123) **Novitas**** L35081 (A54095)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	No	**First Coast** L34859 (A57123) **Novitas**** L35081 (A54095)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
	interpretation; iliac artery, each vessel			Policy titled Lower Extremity Endovascular Procedures.
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0278T	Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Apheresis.
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	No	**NGS** L36831 (A57060)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g., thoracotomy, transapical)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Lower Extremity Endovascular Procedures.
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Musculoskeletal Conditions and Soft Tissue Indications.
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Indications.
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations (Deleted 12/31/2024 – See 89240)	NCD for Human Tumor Stem Cell Drug Sensitivity Assays (190.7)	**Noridian** L37628 (A56071) **Noridian** L37630 (A56073) **Retired** 10/16/2025 **Palmetto**** L34554 (A56871)	Refer to NCD and/or LCD
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Autologous Cellular Therapy.
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	NCD for Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) (20.38)	No	Refer to NCD
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	NCD for Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation (T-TEER) (20.38)	No	Refer to NCD
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0598T	Real-time fluorescence wound imaging with clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; first anatomic site (eg, lower extremity, right leg)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds.
0599T	Real-time fluorescence wound imaging with clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; each additional anatomic site (eg, upper extremity, left leg) (List separately in addition to code for primary procedure)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed (Deleted 12/31/2025 – See 52443)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	No	**CGS** L39958 (A59880) **Noridian** L39960 (A59882) **Noridian** L39962 (A59884) **Retired** 09/11/2025 **Palmetto**** L39942 (A59866)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	No	**CGS** L39958 (A59880) **Noridian** L39960 (A59882) **Noridian** L39962 (A59884) **Retired** 09/11/2025 **Palmetto**** L39942 (A59866)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	No	**CGS** L39958 (A59880) **Noridian** L39960 (A59882) **Noridian** L39962 (A59884) **Retired** 09/11/2025 **Palmetto**** L39942 (A59866)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code)	No	**CGS** L39958 (A59880) **Noridian** L39960 (A59882) **Noridian** L39962 (A59884) **Retired** 09/11/2025 **Palmetto**** L39942 (A59866)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Breast Imaging for Screening and Diagnosing Cancer.
0646T	Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	NCD for Transcatheter Tricuspid Valve Replacement (TTVR) (NCD 20.37)	No	Refer to NCD
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy.
0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy.
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis.
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Processing Evaluation and Orthoptic and Vision Therapy.
0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy.
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Visual Information Processing Evaluation and Orthoptic and Vision Therapy.
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation (Deleted 12/31/2025 – See 64567)	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	NCD for Colonic Irrigation (100.7)	No	Refer to NCD
0737T	Xenograft implantation into the articular surface	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Surgery of the Knee.
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (e.g., polyester, ePTFE, bovine pericardium), when performed	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins.
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Neurophysiologic Testing and Monitoring.
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Gastrointestinal Disorders Diagnostic Procedures.

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial, and right ventricular pacemaker components)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial, and right ventricular pacemaker components)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial, and right ventricular pacemaker components)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcatheter Procedures for Heart Valve Conditions.
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery.
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Bone Healing Enhancement Products.
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
	venography, cavography), when performed			
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (e.g., interrogation or programming), when performed	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	NCD for Leadless Pacemakers (20.8.4)	No	Refer to NCD
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation for Treating Physical Health Conditions.
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Indications.
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50mL	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Prostate Surgeries and Interventions.
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient-symptom profiling, with interpretation and report	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Gastrointestinal Disorders Diagnostic Procedures.
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation for Treating Physical Health Conditions.
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation for Treating Physical Health Conditions.
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation for Treating Physical Health Conditions.
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Transcranial Magnetic Stimulation for Treating Physical Health Conditions.
0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Implantable Loop Recorders and Wearable Heart Rhythm Monitors.
0999T	Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled

CPT Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
				Autologous Cellular Therapy.
1000T	Autologous muscle cell therapy, administration of muscle progenitor cells into the urethral sphincter, including cystoscopy and post-void residual ultrasound, when performed	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.
1001T	Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed	No	No	Not Reasonable and Necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Autologous Cellular Therapy.

Centers for Medicare and Medicaid Services (CMS) Related Documents

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

CMS Benefit Policy Manual

Chapter 16; § 10 General Exclusions from Coverage.

CMS Transmittal(s)

Transmittal 11457, Change Request 12761, Dated 06/15/2022 [July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)].
Transmittal 11472, Change Request 12773, Dated 06/23/2022 [July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System].
Transmittal 12053, Change Request 13210, Dated 05/18/2023 [July 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)].
Transmittal 12122, Charge Request 13216, Dated 07/05/2023 [July 2023 Update of the Ambulatory Surgical Center (ASC) Payment System].
Transmittal 12665, Change Request 13632, Dated 05/31/2024 [July 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)].

Transmittal 12673, Change Request 13656, Dated 06/13/2024 [July 2024 Update of the Ambulatory Surgical Center (ASC) Payment System].
Transmittal 12697, Change Request 13656, Dated 06/25/2024 [July 2024 Update of the Ambulatory Surgical Center (ASC) Payment System].
Transmittal 12765, Change Request 13632, Dated 08/02/2024 [July 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)].
Transmittal 13258, Change Request 14091, Dated 06/23/2025 [July 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)].
Transmittal 13344, Change Request 14101, Dated 08/01/2025 [July 2025 Update of the Ambulatory Surgical Center (ASC) Payment System].

MLN Matters

Article MM12761, July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS).
Article MM12773, July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System.
Article MM13210, July 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS).
Article MM13216, July 2023 Update of the Ambulatory Surgical Center (ASC) Payment System.
Article MM13632, July 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS).
Article MM13656, July 2024 Update of the Ambulatory Surgical Center (ASC) Payment System.
Article MM14091, July 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS).
Article MM14101, July 2025 Update of the Ambulatory Surgical Center (ASC) Payment System.

Others

Medicare Managed Care Manual IOM Pub. No. 100-16, Ch. 4, §90.5.
Physician Fee Schedule Relative Value Files.
Social Security Act (Title XVIII), Section 1862(a)(1)(A) Medically Reasonable & Necessary.
L35490 Category III Codes
A56902 Billing and Coding: Category III Codes

Policy History/Revision Information

Date	Summary of Changes

04/01/2026	**Coverage Rationale**
	• Revised list of applicable CPT codes; removed content/language addressing:
	  ○ Anterior lumbar or thoracolumbar vertebral body tethering (CPT codes 0656T and 0657T)
	  ○ Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy (CPT code 0790T)
	Centers for Medicare & Medicaid Services (CMS) Related Documents
	• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information
	Supporting Information
	• Archived previous policy version MMP043.46

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.