Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Experimental/Investigational Procedures/Services

Policy Number: PG0043
Last Review: 06/01/2024

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

_X_ Professional
_X_ Facility

DESCRIPTION:

Experimental/investigational is used to describe medical, surgical, diagnostic, psychiatric, substance use disorders treatment or other health care services, technologies, equipment, supplies, treatments, procedures, therapies, biologics, drugs, or devices that meets one or more of the following conditions:

- Is the research, experimental, study, or investigational arm of an ongoing Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness as compared with a standard means of treatment or diagnosis;
- Not approved by the United States Food and Drug Administration (FDA) to be lawfully marketed for the proposed use;
- The medical, surgical, diagnostic, psychiatric, substance use disorders treatment or other health care services, technologies, equipment, supplies, treatments, procedures, therapies, biologics, drugs, or devices is provided pursuant to oversight by an institutional review board or other body that approves or reviews research concerning safety, toxicity, or efficacy;
- There is insufficient authoritative evidence that the treatment improves the net health outcome, the clinical evidence supporting effectiveness is insufficient. (Net health outcome means that the treatment's beneficial effects on health outcomes outweigh any harmful effects of the treatment on health outcomes.) There is insufficient authoritative evidence that the treatment is as beneficial as any established alternative. This means that the treatment does not improve net outcome as much as or more than established alternatives;
- Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
- Is not yet recognized as acceptable medical practice, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition;
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, treatment, or procedure is that further studies or clinical trials are necessary to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

Criteria used in determining whether a service is considered experimental or investigational include, but are not limited to:

- Whether the service is commonly performed or used on a widespread geographic basis;
- Whether it is generally accepted practice to treat that illness or injury by the medical profession in the United States;
- Its failure rate and side effects;
- Whether other, more conventional methods of treating the illness or injury have been exhausted by the participant;
- Whether it is medically indicated.

Experimental/Investigational Services are identified as:

- Services Represented by a Specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Code.
- Services without a Specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Code.
- Services with a specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Code, which are reported for other services.

CPT Category III codes represent temporary codes for new and emerging technologies. They have been created to allow for data collection and utilization tracking for new procedures or services. Category III codes are different from Category I CPT codes in that they identify services that may not be performed by many health care professionals across the country, some may not have FDA approval, and some services/procedure have no proven clinical efficacy. Category III codes are intended to be temporary and will be retired if the procedure or service is not accepted as a Category I code within five years. In some instances, Category III codes may replace temporary local codes (HCPCS Level III) assigned by carriers and intermediaries to describe new procedures or services. If a Category III code is available, it must be used instead of the unlisted Category I code. The use of the unlisted code does not offer the opportunity for collection of specific data. The American Medical Association (AMA) releases new codes twice a year in January and July.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Services that are experimental/investigational, as described in this policy, are not eligible for reimbursement consideration. Paramount does not cover investigational/experimental medical or surgical services/procedures that are not medically necessary and have not been strongly supported in research and for which there is a safe and medically accepted alternative available.

All coverage is based on a member's plan documents (subscriber certificate, evidence of coverage).

Paramount uses the following clinical criteria to ensure appropriateness of care and service:

- **Centers for Medicare & Medicaid Service (CMS) for national coverage determinations (NCD). CGS Administrators, LLC., Jurisdiction A/B, and Wisconsin Physicians Service Insurance Corporation for local coverage determinations (LCD).**
- **InterQual Coverage Criteria**
- **Other Paramount Health Care-approved medical policies**
- **In cases of a discrepancy between InterQual and Paramount Medical policies, InterQual will supersede Medical Policy language.**

➢ **Refer to the code listing on the PRIOR AUTHORIZATION – EXPERIMENTAL/INVESTIGATIONAL – NONCOVERED SERVICES, excel spreadsheet https://www.paramounthealthcare.com/providers/claims-and-authorizations/outpatient-prior-authorization**

➢ **To access the InterQual Care Guidelines, click on the following link and follow access instructions: https://identity.onehealthcareid.com/oneapp/index.html#/login**

Non-participating providers are required to obtain prior authorization BEFORE any and all services are rendered.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

The procedures listed as experimental/investigational and not covered, on the PRIOR AUTHORIZATION – EXPERIMENTAL/INVESTIGATIONAL – NONCOVERED SERVICES, excel spreadsheet, are designated because the safety and/or effectiveness of these services cannot be established by review of the available published peer-reviewed literature. This is not an all-inclusive listing. Additionally, some experimental/investigational procedures may be listed within separate medical policies. Providers must refer to the Paramount PRIOR AUTHORIZATION – EXPERIMENTAL/INVESTIGATIONAL – NONCOVERED SERVICES excel spreadsheet listing and specific medical policy in reference to specific procedures for coverage determinations (this list may not be all-inclusive).

The Medical Director or designee may review indications for any Experimental/Investigational Procedure/Services request on an individual basis for medical necessity and appropriateness, taking into consideration the needs of the individual and the member's individual policy coverage. Individual case review may allow coverage for care or treatment that is experimental/investigational yet promising for the conditions described. Requests for individual consideration require Prior Authorization approval. These requests must be supported by the treating provider(s) medical records.

The fact that a treatment is offered as a last resort does not mean that it is not an experimental/investigational treatment and/or would support coverage.

Care outside the United States in not covered.

Elite (Medicare Advantage) Plans

Title XVIII of the Social Security Act, §1862(a)(1)(A) prohibits Medicare coverage for items and services which are not "reasonable and necessary" for the diagnosis and treatment of an injury or illness or to improve the functioning of a malformed body member. According to the Medicare Claims Processing Manual, Chapter 23, §30.A, if a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered because it is not reasonable and necessary to treat illness or injury.

A payment amount in the Medicare Physicians' Fee Schedule (MPFS) does not imply that Medicare has determined the service to be a "reasonable and necessary" covered service. In addition, according to the Medicare Benefit Policy Manual, Chapter 14, while U.S. Food and Drug Administration (FDA) approval does not automatically guarantee coverage under Medicare, in order to even be considered for coverage under Medicare, devices must be either FDA- or Institutional Review Board (IRB) – approved. Therefore, any device that has not received FDA-approval would not be considered medically reasonable or necessary. The FDA reviews data from well-designed studies and clinical trials in order to determine safety and effectiveness prior to approval for sale but does not establish medical necessity of that device or drug. While Medicare may adopt FDA determinations regarding safety and effectiveness, CMS or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A). (Note, not all services or procedures are FDA reviewed and approved.)

Paramount's Experimental Doctrine:

Paramount acquires, processes, and analyzes available scientific literature information regarding the clinical validity, utility, and/or safety and efficacy of a medical service to determine and assign a relevant and reliable listing of experimental/investigational procedures/services. Many of these experimental/investigational procedures/services lack sufficient available published peer-reviewed literature from clinical trials to demonstrate clinical safety and/or efficacy and may not provide long-term benefits in health outcomes within the accepted standards in the medical community.

The term experimental/investigational is used to describe services that address a drug, biological product, device, medical treatment, diagnostic test, or procedure that meets any of the following criteria:

- Is the subject of ongoing clinical trials;

- Is the research, experimental, study, or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by reliable evidence, as effective and appropriate for the diagnosis or treatment of the covered person's particular condition;
- Is generally recognized, based on reliable evidence, by the medical community, as a diagnostic or treatment intervention for which additional study regarding its safety and effectiveness for the diagnosis or treatment of the covered person's particular condition is recommended.

The Medical Policy Steering Committee Workgroup (Medical Director's and Medical Policy staff) routinely conduct evidence-based reviews of new and emerging medical services. This assessment/review may include the following:

- A thorough review of available scientific information, which may include peer-reviewed literature, results of clinical trials, outcomes data, regulatory requirements, and input from professionals' guidelines/exert in the field of the medical service under review, e.g., HAYES;
- Discussion among a multidisciplinary group of health care providers to achieve an adequate understanding of the medical science and its application;
- An appropriate coverage recommendation based on the sum of the evidence.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 07/05/2005

Date	Explanation & Changes
02/15/06	• Updated codes
03/30/06	• Updated codes
01/30/06	• Updated codes
01/01/07	• Updated codes
01/30/08	• Updated codes
01/01/09	• Updated codes
12/01/09	• Updated codes
02/23/11	• Verbiage revision
03/25/16	• Added codes to policy – 0019T, 0042T, 0051T, 0052T, 0053T, 0054T, 0055T, 0058T, 0071T, 0072T, 0075T, 0076T, 0085T, 0095T, 0098T, 0099T, 0100T, 0101T, 0102T, 0103T, 0106T, 0107T, 0108T, 0109T, 0110T, 0111T, 0123T, 0126T, 0159T, 0163T, 0164T, 0165T, 0169T, 0171T, 0172T, 0174T, 0175T, 0178T, 0179T, 0180T, 0182T, 0184T, 0188T, 0189T, 0190T, 0191T, 0195T, 0196T, 0198T, 0200T, 0201T, 0202T, 0205T, 0206T, 0207T, 0208T, 0209T, 0210T, 0211T, 0212T, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0219T, 0220T, 0221T, 0222T, 0223T, 0224T, 0225T, 0228T, 0229T, 0230T, 0231T, 0232T, 0233T, 0234T, 0235T, 0236T, 0237T, 0238T, 0240T, 0241T, 0243T, 0244T, 0249T, 0253T, 0254T, 0255T, 0262T, 0263T, 0264T, 0265T, 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T, 0274T, 0275T, 0278T, 0281T, 0282T, 0283T, 0284T, 0285T, 0286T, 0287T, 0288T, 0289T, 0290T, 0291T, 0292T, 0293T, 0294T, 0295T, 0296T, 0297T, 0298T, 0299T, 0300T, 0301T, 0302T, 0303T, 0304T, 0305T, 0306T, 0307T, 0308T, 0309T, 0310T, 0311T, 0312T, 0313T, 0314T, 0315T, 0316T, 0317T, 0329T, 0330T, 0331T, 0332T, 0333T, 0335T, 0336T, 0337T, 0338T, 0339T, 0340T, 0341T, 0342T, 0345T, 0346T, 0347T, 0348T, 0349T, 0350T, 0351T, 0352T, 0353T, 0354T, 0355T, 0356T, 0357T, 0358T, 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0373T, 0374T, 0375T, 0376T, 0377T, 0378T, 0379T, 0380T, 0381T, 0382T, 0383T, 0384T, 0385T, 0386T, 0387T, 0388T, 0389T, 0390T, 0391T, 0392T, 0393T, 0394T, 0395T, 0396T, 0397T, 0398T, 0399T, 0400T, 0401T, 0402T, 0403T, 0404T,

	0405T, 0406T, 0407T, 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0419T, 0420T, 0421T, 0422T, 0423T, 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, 0436T • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
04/22/16	• Added new PG0366 Percutaneous Left Atrial Appendage Closure (LAAC) to policy (0281T).
11/18/16	• Added effective 07/01/2016 new codes 0437T-0445T as non-covered • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
01/27/17	• Removed effective 12/31/16 deleted codes 0019T, 0169T, 0171T, 0172T, 0281T, 0282T, 0283T, 0284T, 0285T, 0286T, 0287T, 0288T, 0289T, 0291T, 0292T • Added effective 01/01/2017 new codes 0446T-0463T as non-covered • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
03/24/17	• PG0070 Ventricular Assist Devices effective 01/01/2017 new codes 0451T-0463T • PG0213 Interspinous Process Decompression Devices effective 12/31/16 deleted codes 0171T & 0172T • PG0366 Percutaneous Left Atrial Appendage Closure (LAAC) effective 12/31/16 deleted code 0281T • PG0057 Transanal Radiofrequency Therapy – Deleted effective 12/31/16 code 0288T • PG0177 Continuous Blood Glucose Monitoring Services effective 01/01/2017 new codes 0446T-0448T • PG0004 Extracorporeal Shock Wave Therapy (ESWT) effective 12/31/16 deleted code 0019T • PG0395 Leadless Cardiac Pacemakers new policy with codes 0387T-0391T • PG0327 Glaucoma Treatment with Aqueous Drainage Device added code 0356T; effective 07/01/2016 new codes 0444T, 0445T; effective 01/01/2017 new codes 0449T, 0450T • PG0344 Radiofrequency Ablation of Uterine Fibroids effective 12/31/16 deleted code 0336T • PG0166 Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD) effective 12/31/16 deleted codes 0392T & 0393T • Effective 12/31/16 deleted codes: 0169T, 0282T, 0283T, 0284T, 0285T, 0286T, 0287T, 0289T, 0291T, 0292T • Effective 01/01/2017 new codes 0464T-0468T added as non-covered for all product lines • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
09/22/17	• Added new codes 0469T-0473T, 0475T-0478T effective 07-01-17 as non-covered for all product lines • PG0327 Glaucoma Treatment with Aqueous Drainage Device effective 07-01-17 added new code 0474T • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
01/25/18	• Effective 12/31/17 deleted codes 0051T, 0052T, 0053T, 0178T, 0179T, 0180T, 0255T, 0293T, 0294T, 0299T, 0300T, 0301T, 0302T, 0303T, 0304T, 0305T, 0306T, 0307T, 0309T, 0310T, 0340T, & 0438T • Effective 01/01/18 revised codes 0254T & 0333T • Added effective 01/01/18 new codes 0479T-0504T as non-covered for all product lines • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
07/26/18	• Added effective 07/01/18 new codes 0505T-0509T as non-covered for all product lines

	• Removed deleted codes effective 12/31/15 0099T, 0103T, 0123T, 0182T, 0223T, 0224T, 0225T, 0233T, 0240T, 0241T, 0243T, 0244T, 0262T, & 0311T • Refer to PG0440 Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor for coverage determination for code 0398T • Refer to PG0344 Uterine Fibroid Surgical Treatments for coverage determination for codes 0071T, 0072T, 0336T in addition to 0404T • Refer to PG0026 Minimally Invasive Treatment of Back and Neck Pain for coverage determination for codes 0274T & 0275T • Refer to PG0386 Fractional Flow Reserve from Computed Tomography (FFRCT) for coverage determination for codes 0501T-0504T • Refer to PG0418 Retinal Prosthesis for coverage determination for codes 0100T, 0472T, & 0473T • Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG)
12/14/2020	• Medical policy placed on the new Paramount Medical Policy Format
01/01/2022	• Policy reviewed and updated to reflect most current clinical evidence • Changed the title from New/Experimental Technology Procedure/Services to Experimental/Investigational Procedure/Services • Removed deleted codes, 0019T, 0051T, 0052T, 0053T, 0058T, 0085T, 0099T, 0103T, 0111T, 0123T, 0126T, 0159T, 0169T, 0171T, 0172T, 0178T, 0179T, 0180T, 0182T, 0188T, 0189T, 0190T, 0191T, 0195T, 0196T, 0205T, 0206T, 0223T, 0224T, 0225T, 0228T, 0229T, 0230T, 0231T, 0233T, 0240T, 0241T, 0243T, 0244T, 0249T, 0253T, 0254T, 0255T, 0262T, 0281T, 0282T, 0283T, 0284T, 0285T, 0286T, 0287T, 0288T, 0289T, 0290T, 0291T, 0292T, 0293T, 0294T, 0295T, 0296T, 0297T, 0298T, 0299T, 0300T, 0301T, 0302T, 0303T, 0304T, 0305T, 0306T, 0307T, 0309T, 0310T, 0311T, 0336T, 0337T, 0340T, 0341T, 0346T, 0355T, 0356T, 0357T, 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0374T, 0375T, 0376T, 0377T, 0379T, 0380T, 0381T, 0382T, 0383T, 0384T, 0385T, 0386T, 0387T, 0388T, 0389T, 0390T, 0391T, 0392T, 0393T, 0396T, 0399T, 0400T, 0401T, 0405T, 0406T, 0407T, 0423T, 0438T, 0449T, 0481T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0468T, 0482T • Added codes 22526, 22527, 30468, 33274, 33275, 33289, 41512, 41530, 43252, 53451, 53452, 53453, 53454, 55880, 62287, 68841, 75571, 78351, 81490, 91132, 91133, 92145, 92517, 92518, 92519, 93025, 93264, 93590, 93591, 93592, 93702, 95803, 96931, 96932, 96933, 96934, 96935, 96936, 0002M, 0003M, 0004M, 0014M, 0015M, 0018M, 0253T, 0511T, 0512T, 0513T, 0514T, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0523T, 0T25T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, 0532T, 0533T, 0534T, 0535T, 0536T, 0537T, 0538T, 0539T, 0540T, 0541T, 0542T, T546T, 0547T, 0552T, 0553T, 0559T, 0560T, 0561T, 0562T, 0563T, 0564T, 0565T, 0566T, 0567T, T568T, 0571T, 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, 0581T, 0582T, 0583T, 0584T, 0585T, 0586T, 0587T, 0588T, 0589T, 0590T, 0591T, 0592T, 0593T, 0594T, 0596T, 0597T, 0598T, 0599T, 0600T, 0601T, 0602T, 0603T, 0604T, 0605T, 0606T, 0607T, 0608T, 0609T, 0610T, 0611T, 0612T, 0613T, 0614T, 0615T, 0616T, 0617T, 0618T, 0619T, 0621T, 0622T, 0623T, 0624T, 0625T, 0626T, 0627T, 0628T, 0629T, 0630T, 0931T, 0632T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0639T, 0640T, 0641T, 0642T, 0643T, 0644T, 0645T, 0646T, 0647T, 0648T, 0649T, 0651T, 0652T, 0653T, 0654T, 0655T, 0656T, 0657T, 0658T, 0659T, 0660T, 0661T, 0662T, 0663T, 0664T, 0665T, 0666T, 0667T, 0668T, 0669T, 0670T, 0671T, 0672T, 0673T 0674T, 0675T, 0676T, 0677T, 0678T, 0679T, 0680T, 0681T, 0682T, 0683T, 0684T, 0685T, 0686T, 0687T, 0688T, 0689T, 0690T, 0691T, 0692T, 0693T, 0694T, 0695T, 0696T, 0697T, 0698T, 0700T, 0701T, 0702T, 0703T, 0704T, 0705T, 0706T, 0707T, 0708T, 0709T, 0710T, 0711T, 0712T, 0713T, 0002U, 0003U, 0007U, 0011U, 0021U, 0024U, 0025U, 0025U, 0038U, 0051U, 0052U, 0054U,

	0055U, 0058U, 0059U, 0061U, 0062U, 0064U, 0066U, 0067U, 0077U, 0080U, 0082U, 0083U, 0086U, 0092U, 0093U, 0095U, 0096U, 0105U, 0106U, 0107U, 0108U, 0110U, 0112U, 0114U, 0115U, 0116U, 0117U, 0119U, 0121U, 0122U, 0123U, 0140U, 0141U, 0142U, 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U, 0151U, 0152U, 0163U, 0164U, 0165U, 0166U, 0167U, 0176U, 0178U, 0206U, 0207U, 0210U, 0219U, 0223U, 0225U, 0227U, 0228U, 0242U, 0244U, 0243U, 0245U, 0247U, 0248U, 0250U, 0251U, 0252U, 0253U, 0254U, 0255U, 0256U, 0257U, 0258U, 0259U, 0260U, 0261U, 0262U, 0263U, 0264U, 0266U, 0267U, 0301U, 0302U, 0303U, 0304U, 0305U, 0308U, 0309U, 0310U, 0311U, 0312U, 0316U, 0321, 0322U, A4563, A4575, C1052, C1761, C1839, C1841, C1842, C2624, C9122, C9759, C9764, C9765, C9766, C9767, C9772, C9773, C9774, C9775, C9777, E0740, G2171, G0460, K1002, K1004, K1009, K1016, K1017, K1018, K1019, K1023, K1026, K1027, M0076, P2031, S1090, S1091, S2107, S2300, S2348, S8080, S9055 • Added medical, surgical, diagnostic, psychiatric, substance use disorders treatment or other health care services, technologies, equipment, supplies, treatments, procedures, therapies, biologics, drugs, or device that may not have a CPT/HCPCS Code
03/29/2022	• Added documentation related to noncoverage for Amniotic Fluid and/or Placental Tissue Biological Injections • Added coverage/noncoverage for Peristeen Anal Irrigation System (A4459)
05/02/2022	• Updated noncoverage criteria for procedure G0460 effective 1/1/2022 • Added noncoverage and PA requirement for procedure G0465 • Added medical policy PG0318 Vision Therapy documentation to procedures 0687T, 0688T, 0704T, 0705T, 0706T • Added PG0320 Bone Density Measurements documentation, procedures 77089, 77090, 77091, 77092, 78350, 78351, 0508T, 0554T, 0555T, 0556T, 0557T and 0691T as they are considered experimental/investigational/unproven • Added age coverage documentation for procedure 0511T • Added medical policy PG0402 Cognitive Rehabilitation to procedures 0702T and 0703T • Added J7401 for noncoverage per medical policy PG0384 Drug Eluting Devices for Use Following Endoscopic Sinus Surgery
05/19/2022	• Corrected a typo mistake, procedure S4130 corrected to S8130 • Removed procedure 0244U, procedure 0244U is addressed in the genetic medical policy PG0041
05/25/2022	• Added miraDry to the list of noncovered services, PG0466 Hyperhidrosis Treatment (excluding botox)
06/21/2022	• Removed procedures 0424T-0436T, procedures now covered with prior authorization, PG0508 Phrenic Nerve Stimulation for Central Sleep Apnea
06/22/2022	• Added PG0510 Scintimammography and Gamma Imaging of the Breast and Axilla to HCPCS code S8080 listed as non-covered, new medical policy
07/01/2022	• Added PG0224 Cardioverter Defibrillators to procedure codes 0571T, 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, 0695T, and 0696T
07/15/2022	• Added PG0206 Laser Interstitial Thermal Therapy (LITT) procedure codes 61736 and 61737 • Added procedures 64628 and 64629, PG0361 Alternative Radiofrequency Methods of Denervation: Noncovered
07/22/2022	• Added procedure C9781, subacromial spacer, as non-covered
09/19/2022	• Added that procedures 0446T, 0447T and 0448T are covered for the Elite/ProMedica Medicare Plan effective 01/01/2022. Noncovered for all other product lines. PG0177 Continuous Blood Glucose Monitoring Services
10/03/2022	• Removed procedures 64628 and 64629, Refer to medical policy PG0512 Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain

10/31/2022	• Added procedure 0342U as noncovered – experimental/investigational, effective 10/1/2022
11/01/2022	• Added the Vibrant Capsule System as noncovered – experimental/investigational, effective immediately
11/14/2022	• Added procedure code S3652 as noncovered – experimental/investigational, effective immediately
12/12/2022	• Paramount has added the following non-covered procedure codes – 0715T, 0716T, 0719T, 0720T, 0721T, 0722T, 0723T, 0724T, 0730T, 0731T, 0732T, 0735T, 0736T, 0737T, 0738T, 0739T, 0744T, 0745T, 0746T, 0747T, 0748T, 0751T, 0752T, 0753T, 0754T, 0755T, 0756T, 0757T, 0758T, 0759T, 0760T, 0761T, 0762T, 0763T, 0764T, 0765T, 0766T, 0767T, 0768T, 0769T, 0776T, 0777T, 0778T, 0779T, 0781T, 0782T, 0783T as experimental/investigational, effective 01/01/2023
01/01/2023	• Paramount has added the noncoverage for progenitor cell therapy for the treatment of damaged myocardium (CardiAMP)
01/18/2023	• Paramount removed the noncoverage documentation for the Vibrant Capsule System from the Experimental/Investigational Procedures/Services medical policy. • The Vibrant Capsule System is now managed under the pharmacy benefit with prior authorization • Paramount added documentation related to the coverage and noncoverage for Quantitative Pupillometry/Pupillography, medical policy PG0319
02/01/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
03/03/2023	• Added Pro2cool to the listing of noncovered services
04/13/2023	• Added codes 0346U, 0358U, 0361U • Added codes 31660, 31661 • Added PG0316 to reference 0781T, 0782T • Added code S9001 • Added code 93701
05/11/2023	• Codes 0394T and 0395T covered with prior authorization for Medicare Advantage Plans. • Code 64625 non-covered effective 08/01/2023.
05/25/2023	• Added Paramount's Experimental/Investigational Doctrine • Added code 92512, PG0045 Rhinomanometry & Acoustic – Optical Rhinometry • Added Lenire Device (Neuromod Devices Ltd.) for Tinnitus as Non-covered
06/06/2023	• Added code 46948 and Emborrhoid technique, PG0329 Hemorrhoidal Dearterialization
06/25/2023	• 93702 updated to indicate PG0347 Archived and Bioimpedance Spectroscopy non-covered added to medical policy PG0295 Treatment of Lymphedema • Added Transanal radiofrequency therapy for the treatment of fecal incontinence (e.g., Secca procedure) PG0057 Transanal Radiofrequency Therapy • Added Avise PG and Avise MTX, PG0194 Avise Testing for Methotrexate Polyglutamate Levels in Rheumatoid Arthritis Therapy
7/13/2023	• Added PG0004 Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions and Soft Tissue Wounds code 28890 as non-covered • Added PG0166 Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD) codes 43201 and 43236 as non-covered • Added PG0028 Wireless Capsule Endoscopy & GI Motility Monitoring code 91112 as non-covered
07/17/2023	• Added 0733T and 0734T • Added PrismRA • Removed procedure 0042T. Effective 8/1/2023 procedure 0042T is covered, all product lines, PG0297 Cerebral Perfusion Analysis
07/27/2023	• Added QuickSIN noncoverage from archived medical policy PG0307 The QuickSIN Test, unlisted procedure code 92700-*Unlisted otorhinolaryngological service or procedure* • Added Hearing In Noise Test – HINT, also known as Speech in Noise, as Non-Covered

08/16/2023	• Added Vertebral Axial Decompression, PG0036, procedures S9090. • Added procedure 87900 from PG0346 HIV Genotyping and Phenotyping Laboratory Testing. Also added the medical policy number for the listed procedure code 0219U
08/21/2023	• Added procedure S8930-PG0244 Electrical Nerve Stimulators • Added PG0244 Electrical Nerve Stimulators to procedure 0783T
09/06/2023	• Removed procedures 0450T and 0671T.Effective 10/01/2023 procedures 0450T and 0671T are covered when the coverage criteria indicated below is met, PG0327 Glaucoma Treatment with Aqueous Drainage Device • Added Paramount considers peripheral nerve stimulation using the ReActiv8 Implantable Neurostimulation System and the StimQ Peripheral Neurostimulation System investigational and not eligible for reimbursement. PG0406 Implantable Peripheral Nerve Stimulation
10/05/2023	• Added procedure codes 81535, 81536, 0324U, 0325U related to medical policy PG0122 In Vitro Chemoresistance & Chemosensitivity Assays • Updated procedure codes 0083U, 0248U and 0564U to identify with medical policy PG0122 In Vitro Chemoresistance & Chemosensitivity Assays • Added the noncovered vasectomy procedures, related to medical policy PG0288 Vasectomy Procedures
10/26/2023	• Added procedure code 33269, K1007 • Effective 5/17/2023, 33289 and 93264 are non-covered for Medicare Advantage Plans
11/22/2023	• Added the Tula Iontophoresis System and the Hummingbird Tympanostomy Tube System as non-covered. • Added procedures 33370, 0345T, 0483T, 0484T, 0543T, 0544T, 0545T, 0569T, 0570T, 0646T, 0805T, 0806T are non-covered, PG0108 Transcatheter Heart Valve Procedures. • Added Zoll Heart Failure Management System (HFMS) as non-covered.
12/20/2023	• Added non-covered HCPCS Code A9292, E0490, E0491, and K1036.
01/01/2024	• Effective 12/31/2023, removed deleted codes 0014M, 0404T, 0465T, 0499T, 0501T, 0502T, 0503T, 0504T, 0715T, 0768T, 0769T, 0775T, and 0809T • Effective 01/01/2024, added new, non-covered codes 0789T, 0816T, 0817T, 0818T, 0819T, 0858T • Effective 01/01/2024, added 43290, 43291, 52284, 67516, 81517, 92972, 0312T, 0317T, 0813T as noncovered
02/13/2024	• Medical Policy placed on new Paramount Medical Policy Format • Added the Elastomeric Infusion Pump noncoverage, PG0152 Postoperative Continuous Local Delivery of Anesthesia for Pain Control (Elastomeric Infusion Pump), procedures A4305 and A4306 • Added non-covered procedures 0725T, 0726T, 0727T, 0728T, 0729T, PG0193 Treatment of Chronic Vertigo • Correct documentation related to procedure 0308T. Procedure 0308T is covered, when coverage criteria is met, with a prior authorization for the Paramount Commercial Insurance Plans and Paramount Elite Plans (Medicare Advantage), Medical Policy PG0351 The Implantable Miniature Telescope (IMT) • Deleted the noncoverage of procedure 0421T, effective 04/01/2024, for all product lines, PG0534 Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH). • Added noncovered procedure code 0714T, Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance
02/22/2024	• Updated procedures 0662T and 0663T – PG0535 Scalp cooling Devices to Prevent Hair Loss During Chemotherapy NON-COVERED for Paramount Commercial Plans
02/28/2024	• Added medical policy PG0252 Noninvasive Tests for Hepatic Fibrosis documentation to procedure codes 0648T, 0649T, 0116U • Added procedure 0344U to noncoverage

	• Removed the noncoverage for procedure 0002M, 0003M, 81517-now allows coverage PG0252 Noninvasive Tests for Hepatic Fibrosis
03/14/2024	• Added retinal prosthesis procedure codes 0100T, 0472T, 0473T are noncovered for Paramount Commercial Insurance Plans only, medical policy PG0418 Retinal Prosthesis
03/18/2024	• Removed/Crossed out Procedure 0398T – Effective 01/01/2024 allowed coverage for the Paramount Commercial Insurance Plans (already was allowed coverage for the Elite (Medicare Advantage Plans). PG0440 Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor • Added procedure 0814T- noncovered experimental/investigational – PG0365 Bone Graft Substitutes • Removed/Crossed out Procedure 0402T – Effective 01/01/2024 allowed coverage for all product lines • Added Edison System for Histotripsy of Renal Tumors, Non-Covered. Review completed at the Med-Tech Pipeline Workgroup.
03/28/2024	• Added noncovered procedures 0360U and 0406U, medical policy PG0476 Proteomic Testing in the Management of Pulmonary Nodules • Added noncovered procedures 0091U and 0421U, medical policy PG0065 Colorectal Cancer Screening • Removed procedure 93025 noncoverage. Effective 04/01/2024 coverage allowed for all product lines when coverage criteria are met. PG0478 Electrocardiograms
05/01/2024	• Added non-covered code E2001 • Removed code 0858T. Effective 06/01/2024 procedure 0858T will require a prior authorization. PG0294 Transcranial Magnetic Stimulation (TMS). • Added non-covered code 0792T • Removed codes 0591T, 0592T and 0593T. Per CMS 2024 Telehealth updates, these codes are covered • Added Non-Medical IV Hydration Therapy Services outside of Standard Medical Practice are non-Covered. Medically Indicated IV Hydration requires a qualified licensed practitioner order, administered at a covered place of service by a licensed provider. • Removed code 93025, effective 04/01/2024 • Added codes 40806 and 40819, from the archived medical policy PG0407 • Added noncoverage of a virtual colonoscopy using MRI, from the archived medical policy PG0182 • Added noncoverage of V5273
06/01/2024	• Updated the medical policy to only include the experimental/investigational coverage criteria • The experimental/investigational, noncovered code table has been deleted and placed on the Paramount PRIOR AUTHORIZATION – EXPERIMENTAL/INVESTIGATIONAL – NONCOVERED SERVICES excel spreadsheet

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to
https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS

Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/ Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review