Local Coverage Article:
Billing and Coding: Noncovered Services other than CPT® Category III Noncovered Services (A56506)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

Article Information

General Information

Article ID
A56506

Article Title
Billing and Coding: Noncovered Services other than CPT® Category III Noncovered Services

Article Type
Billing and Coding

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
05/05/2019

Revision Effective Date
10/27/2019

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

Title XVIII of the Social Security Act §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Internet-Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 23, §30A Services Paid Under the Medicare Physician's Fee Schedule

CMS Internet-Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 30, §50.3.1 Mandatory ABN Uses

Article Guidance

Article Text:

The information in this article contains billing, coding or other guidelines that complement the Local Coverage

Determination (LCD) for Noncovered Services other than CPT® Category III Noncovered Services L36954.

Coverage Indications, Limitations and/or Medical Necessity

Although a payment amount for a particular service may appear in the Medicare fee schedule, this listing alone does not guarantee Medicare coverage or reimbursement for that service. The presence of a payment amount in the Medicare Physician Fee Schedule (MPFS) and the Medicare Physician Fee Schedule Database (MPFSDB) does not imply that the Centers for Medicare and Medicaid (CMS) has determined that the service is covered by Medicare. The only status indicator that influences coverage is N, which indicates a non-covered service. A Medicare Administrative Contractor (MAC) may determine whether a service is reasonable and necessary. If a service is determined not to be reasonable and necessary, MACs may consider the service to be non-covered.

It is also important to note that when a new service or procedure has been issued a CPT® code or is FDA approved for a specific indication; that does not in itself render the procedure (or the device which has received FDA approval) medically reasonable and necessary. Palmetto GBA evaluates new services, procedures, drugs or technology based on peer-reviewed literature, the results of clinical trials, etc., and considers national and local policies before these new services may be accepted as Medicare covered services in Jurisdiction J and M in the absence of a specific coverage decision issued by CMS.

This article contains listings of numerous non-covered services which have no specific CPT® code. In some instances there exists two or more unlisted codes that could arguably be used to designate the service. In such cases, the absence of a code from this article does not guarantee that the service billed will be covered when billed under a different code. **Therefore**, providers must bear in mind that **any** service that is described in any Palmetto GBA LCD or article as "non-covered" will remain non-covered no matter which CPT® code is selected for billing. Occasionally when a service is billed with an unlisted code it may be unclear as to exactly what service was supplied and a payment may be made in error for a noncovered service. Providers are reminded that these paid services will be subject to recoupment by Palmetto GBA, as well as other review contractors, including the Recovery Auditors (RAs), Zone Program Integrity Contractors (ZPICs), etc.

Services that this contractor considers a component of another service and never separately billable or payable are also included here unless those services are already included in the mutually exclusive Correct Coding Initiative (CCI) edits implemented by CMS. For some services, one or more of the Medicare payment systems (for example, the MPFS or the Outpatient Prospective Payment System (OPPS)) may indicate that the service is bundled or packaged or not paid for some other reason, in which case those indicators take precedence over the placement in this article.

List of (bundled) components that are not separately billable to the Contractor or the Beneficiary:

- Allergy - AG prep
- Anesthesia intravenous (IV) start or intubation
- Angiojet thrombectomy any artery or vein
- Application/instillation of mitomycin
- Cast mold

- CorMatrix
- Coronary sinus venography
- Embolic protection device
- Eye retractor advancement
- GliaSite® balloon placement
- Implantation/placement of antibiotic beads
- Implantation of Doppler device
- Intrapericardial defibrillator coil
- Intraoperative blood flow measurement
- ON-Q® pain pump placement and/or management
- Pentacam®
- Peripherally inserted central catheter (PICC) removal (when billed by same provider)
- Pin fixation
- Pope earwick
- Potential acuity meter
- Propel® sinus implant
- Pump catheter placement
- Pupillography or measure of alertness by pupillometry
- Resection/ligation of atrial appendage
- Schirmer test (ophthalmic mucous membrane test)
- Stat fee
- Stryker pain pump insertion

- Suture removal (when billed by same provider)
- Symphony system for procedure
- Two week home auto continuous positive airway pressure (CPAP) titration study
- Ultrasound (US) guidance for fiducial marker placement
- Via modem transmission telemedicine
- Visiometer testing

The content of this article is not an all-inclusive list of non-covered services or those services not paid separately by Medicare. This article post-dates existing LCDs and articles that address specific non-covered services that may not be repeated within this article.

Compliance with the provisions in this article is subject to monitoring by post payment data analysis and subsequent medical review which may result in recoupment of Medicare payments.

The HCPCS/CPT® code(s) may be subject to Correct Coding Initiative (CCI) edits in addition to guidance in this LCD. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare. Whichever guidance is more restrictive should be adhered to.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

Non-Coverage Determinations:

Note: The following lists of non-covered services are not all-inclusive:

To bill the patient for procedures and services that are not covered for these reasons will generally require an Advance Beneficiary Notice (ABN) to be obtained before the service is rendered.

All new Category III Codes, unless specifically approved for payment by CMS or Palmetto GBA are non-covered. A listing a Category III codes not covered by Palmetto GBA appears in a separate LCD-L34555 Non-Covered Category III CPT® Codes. In most cases, in accordance with the CPT® Manual, these codes have been created to track new, "emerging" unproven therapies and tests. If a provider or other interested party believes that a service described by a Category III code or any other code in this policy is medically reasonable and necessary, the provider or party should submit peer-reviewed medical literature, that supports the safety and effectiveness of the service. A request for coverage of the service may be made through the Palmetto GBA LCD Reconsideration Process.

Group 1 - Not Proven Effective, Not Medically Reasonable and Necessary

• Accu-Spina^{TM}

• Analysis of patient-specific findings with quantifiable computer probability assessment, including report

• Antiprothrombin (phospholipid cofactor) antibody, each immunoglobulin (IG) class

• Bile duct extracorporeal shock-wave lithotripsy (ESWL)

• ESWL for musculoskeletal conditions

• Breast ductoscopy

• Breast Specific Gamma Imaging (BSGI)

• Carbon monoxide, expired gas analysis [eg., end-tidal carbon monoxide (ETCO)/hemolysis breath test]

• Circular boot treatment

• Clinical drug interaction testing

• Coblation debridement of tendon and/or fascia

• Computed tomography (CT) fusion

• Destruction of macular drusen, photocoagulation

• Electrical impedance breast scan

• Flicker Fusion

• Provocative and neutralization testing and neutralization therapy of food allergies (sublingual, intracutaneous and subcutaneous)

• Gel platelet application

• Head shaking test

• Heidelberg Gastric Analysis Test

• Hydrotherapy treatments (also known as hydromassage & hydrobed modality)

- Hypertonic sinus irrigation
- Inert gas rebreathing for cardiac output measurement; during rest
- Inert gas rebreathing for cardiac output measurement; during exercise
- Laser myringotomy
- Laser treatment or low light laser therapy: of rotator cuff tendonitis, to stimulate circulation, for pain and inflammation, for low level laser treatment including, but not limited to trigger points, knees, hips and other joints
- Leukocytes, stool
- Lipoprotein, direct measurement, intermediate density lipoproteins [IDL][remnant lipoprotein]
- Lung spectroscopy
- Mammary duct(s) catheter lavage
- Microvas Treatments for all indications other than those allowed by NCD 270.1
- Microdose therapy for arthritis or fibromyalgia
- Microwave phased array thermotherapy for destruction/reduction of malignant breast tumor
- M.O.S.T. protocol (Mental office-based stress test)
- Neuroform® Stent placement for ischemic disease
- Palate implant procedure (Pillar® System)
- Percutaneous neuromodulation therapy
- PFL CO monitor
- Phonophoresis
- Platelet plasma mixed with laminate, protein bone growth stimulator
- Platelet rich plasma (PRP) injection for osteoarthrosis
- Provocation and Neutralization Allergy Testing

• Pulsed magnetic neuromodulation incontinence treatment

• Pulsed radiofrequency treatment

• QCare

• Reconstruction of iliac bone or crest

• Rhinophototherapy, intranasal application of ultraviolet and visible light

• Saccades eye test or Saccadic eye test

• Secca® procedure

• Sonorex treatment

• Speculoscopy, including sampling

• Splint mouth guard or night guard

• Sublingual antigen drops

• Suprachoroidial delivery of pharmacologic agent

• Therabite® Jaw Motion Rehabilitation System™ appliance dispensed to treat trismus

• Therapy using Superluminous Diodes

• Transmyocardial transcatheter closure of ventricular septal defect, with implant, including cardiopulmonary bypass if performed

• Ultrafiltration in heart failure

• Urinalysis infectious agent detection, semi quantitative analysis of volatile compounds

• Vagal nerve stimulation for depression

• von Willebrand Propetide Ag

Note: The above services, regardless of submitted CPT® and/or HCPCS code, are not medically reasonable and necessary and will be denied as such:

Additional non-covered CPT® codes are listed in the Group 1: Codes section below.

Group 1 Codes:

CODE	DESCRIPTION
01990	PHYSIOLOGICAL SUPPORT FOR HARVESTING OF ORGAN(S) FROM BRAIN-DEAD PATIENT
15824	RHYTIDECTOMY; FOREHEAD
15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK
15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK
15877	SUCTION ASSISTED LIPECTOMY; TRUNK
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
17380	ELECTROLYSIS EPILATION, EACH 30 MINUTES
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA
20985	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES, IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN ANESTHESIA SERVICE (IE, GENERAL OR MONITORED ANESTHESIA CARE)
21811	OPEN TREATMENT OF RIB FRACTURE(S) WITH INTERNAL FIXATION, INCLUDES THORACOSCOPIC VISUALIZATION WHEN PERFORMED, UNILATERAL; 1-3 RIBS
22586	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, WITH POSTERIOR INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED, L5-S1 INTERSPACE
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR
28446	OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT[S])
28890	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REQUIRING ANESTHESIA OTHER THAN LOCAL, INCLUDING ULTRASOUND GUIDANCE, INVOLVING THE PLANTAR FASCIA
29868	ARTHROSCOPY, KNEE, SURGICAL; MENISCAL TRANSPLANTATION (INCLUDES ARTHROTOMY FOR MENISCAL INSERTION), MEDIAL OR LATERAL
32998	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE

CODE	DESCRIPTION
	PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL; RADIOFREQUENCY
41530	SUBMUCOSAL ABLATION OF THE TONGUE BASE, RADIOFREQUENCY, 1 OR MORE SITES, PER SESSION
43257	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF LOWER ESOPHAGEAL SPHINCTER AND/OR GASTRIC CARDIA, FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA [SIS])
53860	TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE
58321	ARTIFICIAL INSEMINATION; INTRA-CERVICAL
58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE
58323	SPERM WASHING FOR ARTIFICIAL INSEMINATION
58670	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (EG, BAND, CLIP, OR FALOPE RING)
58970	FOLLICLE PUNCTURE FOR OOCYTE RETRIEVAL, ANY METHOD
58974	EMBRYO TRANSFER, INTRAUTERINE
58976	GAMETE, ZYGOTE, OR EMBRYO INTRAFALLOPIAN TRANSFER, ANY METHOD
59012	CORDOCENTESIS (INTRAUTERINE), ANY METHOD
62263	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 2 OR MORE DAYS
62264	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 1 DAY
62287	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, ANY METHOD UTILIZING NEEDLE BASED TECHNIQUE TO REMOVE DISC MATERIAL UNDER FLUOROSCOPIC IMAGING OR OTHER FORM OF INDIRECT VISUALIZATION, WITH DISCOGRAPHY AND/OR EPIDURAL INJECTION(S) AT THE TREATED LEVEL(S), WHEN PERFORMED, SINGLE OR MULTIPLE LEVELS, LUMBAR
65785	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS

CODE	DESCRIPTION
76981	ULTRASOUND, ELASTOGRAPHY; PARENCHYMA (EG, ORGAN)
76982	ULTRASOUND, ELASTOGRAPHY; FIRST TARGET LESION
76983	ULTRASOUND, ELASTOGRAPHY; EACH ADDITIONAL TARGET LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
82016	ACYLCARNITINES; QUALITATIVE, EACH SPECIMEN
82017	ACYLCARNITINES; QUANTITATIVE, EACH SPECIMEN
82777	GALECTIN-3
83006	GROWTH STIMULATION EXPRESSED GENE 2 (ST2, INTERLEUKIN 1 RECEPTOR LIKE-1)
83987	PH; EXHALED BREATH CONDENSATE
84066	PHOSPHATASE, ACID; PROSTATIC
84134	PREALBUMIN
84431	THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE
86305	HUMAN EPIDIDYMIS PROTEIN 4 (HE4)
86343	LEUKOCYTE HISTAMINE RELEASE TEST (LHR)
87084	CULTURE, PRESUMPTIVE, PATHOGENIC ORGANISMS, SCREENING ONLY; WITH COLONY ESTIMATION FROM DENSITY CHART
88375	OPTICAL ENDOMICROSCOPIC IMAGE(S), INTERPRETATION AND REPORT, REAL-TIME OR REFERRED, EACH ENDOSCOPIC SESSION
89250	CULTURE OF OOCYTE(S)/EMBRYO(S), LESS THAN 4 DAYS;
89251	CULTURE OF OOCYTE(S)/EMBRYO(S), LESS THAN 4 DAYS; WITH CO-CULTURE OF OOCYTE(S)/EMBRYOS
89253	ASSISTED EMBRYO HATCHING, MICROTECHNIQUES (ANY METHOD)
89254	OOCYTE IDENTIFICATION FROM FOLLICULAR FLUID
89255	PREPARATION OF EMBRYO FOR TRANSFER (ANY METHOD)
89257	SPERM IDENTIFICATION FROM ASPIRATION (OTHER THAN SEMINAL FLUID)
89258	CRYOPRESERVATION; EMBRYO(S)
89259	CRYOPRESERVATION; SPERM
89260	SPERM ISOLATION; SIMPLE PREP (EG, SPERM WASH AND SWIM-UP) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS
89261	SPERM ISOLATION; COMPLEX PREP (EG, PERCOLL GRADIENT, ALBUMIN GRADIENT) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS
89264	SPERM IDENTIFICATION FROM TESTIS TISSUE, FRESH OR CRYOPRESERVED

CODE	DESCRIPTION
89268	INSEMINATION OF OOCYTES
89272	EXTENDED CULTURE OF OOCYTE(S)/EMBRYO(S), 4-7 DAYS
89280	ASSISTED OOCYTE FERTILIZATION, MICROTECHNIQUE; LESS THAN OR EQUAL TO 10 OOCYTES
89281	ASSISTED OOCYTE FERTILIZATION, MICROTECHNIQUE; GREATER THAN 10 OOCYTES
89290	BIOPSY, OOCYTE POLAR BODY OR EMBRYO BLASTOMERE, MICROTECHNIQUE (FOR PRE-IMPLANTATION GENETIC DIAGNOSIS); LESS THAN OR EQUAL TO 5 EMBRYOS
89291	BIOPSY, OOCYTE POLAR BODY OR EMBRYO BLASTOMERE, MICROTECHNIQUE (FOR PRE-IMPLANTATION GENETIC DIAGNOSIS); GREATER THAN 5 EMBRYOS
89335	CRYOPRESERVATION, REPRODUCTIVE TISSUE, TESTICULAR
89337	CRYOPRESERVATION, MATURE OOCYTE(S)
89342	STORAGE (PER YEAR); EMBRYO(S)
89343	STORAGE (PER YEAR); SPERM/SEMEN
89344	STORAGE (PER YEAR); REPRODUCTIVE TISSUE, TESTICULAR/OVARIAN
89346	STORAGE (PER YEAR); OOCYTE(S)
89352	THAWING OF CRYOPRESERVED; EMBRYO(S)
89353	THAWING OF CRYOPRESERVED; SPERM/SEMEN, EACH ALIQUOT
89354	THAWING OF CRYOPRESERVED; REPRODUCTIVE TISSUE, TESTICULAR/OVARIAN
89356	THAWING OF CRYOPRESERVED; OOCYTES, EACH ALIQUOT
90476	ADENOVIRUS VACCINE, TYPE 4, LIVE, FOR ORAL USE
90477	ADENOVIRUS VACCINE, TYPE 7, LIVE, FOR ORAL USE
90581	ANTHRAX VACCINE, FOR SUBCUTANEOUS OR INTRAMUSCULAR USE
90585	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR TUBERCULOSIS, LIVE, FOR PERCUTANEOUS USE
90620	MENINGOCOCCAL RECOMBINANT PROTEIN AND OUTER MEMBRANE VESICLE VACCINE, SEROGROUP B (MENB-4C), 2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90621	MENINGOCOCCAL RECOMBINANT LIPOPROTEIN VACCINE, SEROGROUP B (MENB-FHBP), 2 OR 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90625	CHOLERA VACCINE, LIVE, ADULT DOSAGE, 1 DOSE SCHEDULE, FOR ORAL USE
90632	HEPATITIS A VACCINE (HEPA), ADULT DOSAGE, FOR INTRAMUSCULAR USE
90633	HEPATITIS A VACCINE (HEPA), PEDIATRIC/ADOLESCENT DOSAGE-2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE

CODE	DESCRIPTION
90634	HEPATITIS A VACCINE (HEPA), PEDIATRIC/ADOLESCENT DOSAGE-3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90644	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS C & Y AND HAEMOPHILUS INFLUENZAE TYPE B VACCINE (HIB-MENCY), 4 DOSE SCHEDULE, WHEN ADMINISTERED TO CHILDREN 6 WEEKS-18 MONTHS OF AGE, FOR INTRAMUSCULAR USE
90647	HAEMOPHILUS INFLUENZAE TYPE B VACCINE (HIB), PRP-OMP CONJUGATE, 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90648	HAEMOPHILUS INFLUENZAE TYPE B VACCINE (HIB), PRP-T CONJUGATE, 4 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90649	HUMAN PAPILLOMAVIRUS VACCINE, TYPES 6, 11, 16, 18, QUADRIVALENT (4VHPV), 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90650	HUMAN PAPILLOMAVIRUS VACCINE, TYPES 16, 18, BIVALENT (2VHPV), 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE
90680	ROTAVIRUS VACCINE, PENTAVALENT (RV5), 3 DOSE SCHEDULE, LIVE, FOR ORAL USE
90681	ROTAVIRUS VACCINE, HUMAN, ATTENUATED (RV1), 2 DOSE SCHEDULE, LIVE, FOR ORAL USE
90690	TYPHOID VACCINE, LIVE, ORAL
90691	TYPHOID VACCINE, VI CAPSULAR POLYSACCHARIDE (VICPS), FOR INTRAMUSCULAR USE
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY
91132	ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS;
CODE	DESCRIPTION
91133	ELECTROGASTROGRAPHY, DIAGNOSTIC, TRANSCUTANEOUS; WITH PROVOCATIVE TESTING
92145	CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
92970	CARDIOASSIST-METHOD OF CIRCULATORY ASSIST; INTERNAL
92971	CARDIOASSIST-METHOD OF CIRCULATORY ASSIST; EXTERNAL
92997	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; SINGLE VESSEL
92998	PERCUTANEOUS TRANSLUMINAL PULMONARY ARTERY BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
93702	BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)

CODE	DESCRIPTION
94014	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; INCLUDES REINFORCED EDUCATION, TRANSMISSION OF SPIROMETRIC TRACING, DATA CAPTURE, ANALYSIS OF TRANSMITTED DATA, PERIODIC RECALIBRATION AND REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
94015	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; RECORDING (INCLUDES HOOK-UP, REINFORCED EDUCATION, DATA TRANSMISSION, DATA CAPTURE, TREND ANALYSIS, AND PERIODIC RECALIBRATION)
94016	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; REVIEW AND INTERPRETATION ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
C1749	ENDOSCOPE, RETROGRADE IMAGING/ILLUMINATION COLONOSCOPE DEVICE (IMPLANTABLE)
C1830	POWERED BONE MARROW BIOPSY NEEDLE
C9727	INSERTION OF IMPLANTS INTO THE SOFT PALATE; MINIMUM OF THREE IMPLANTS
C9734	FOCUSED ULTRASOUND ABLATION/THERAPEUTIC INTERVENTION, OTHER THAN UTERINE LEIOMYOMATA, WITH MAGNETIC RESONANCE (MR) GUIDANCE
J2010	INJECTION, LINCOMYCIN HCL, UP TO 300 MG
J3530	NASAL VACCINE INHALATION
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (LILETTA), 52 MG
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA), 52 MG
J7330	AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT

Group 2 Paragraph:

Statutorily Non-covered Service, the Beneficiary is Liable for Payment

- Astigmatic keratotomy
- CO2 laser resurfacing of lip
- INTIMA-MEDIA Thickness (IMT) Scan
- Occlusal orthotic appliance
- Orthomolecular medicine

Group 2 Codes:

CODE	DESCRIPTION
97545	WORK HARDENING/CONDITIONING; INITIAL 2 HOURS
97546	WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Group 3 Paragraph:

There are currently no accepted indications for the surgical decompression of diabetic, other metabolic or toxic, or idiopathic polyneuropathy. Neither the procedure nor the anesthesia services for the procedure will be considered medically necessary.

Group 3 Codes:

CODE	DESCRIPTION
28035	RELEASE, TARSAL TUNNEL (POSTERIOR TIBIAL NERVE DECOMPRESSION)
64702	NEUROPLASTY; DIGITAL, 1 OR BOTH, SAME DIGIT
64704	NEUROPLASTY; NERVE OF HAND OR FOOT
64708	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG, OPEN; OTHER THAN SPECIFIED
64712	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG, OPEN; SCIATIC NERVE
64714	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG, OPEN; LUMBAR PLEXUS
64722	DECOMPRESSION; UNSPECIFIED NERVE(S) (SPECIFY)
64726	DECOMPRESSION; PLANTAR DIGITAL NERVE
64727	INTERNAL NEUROLYSIS, REQUIRING USE OF OPERATING MICROSCOPE (LIST SEPARATELY IN ADDITION TO CODE FOR NEUROPLASTY) (NEUROPLASTY INCLUDES EXTERNAL NEUROLYSIS)

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

These ICD-10 codes do not support medical necessity for **Group 3 CPT Codes**:

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
A52.15	Late syphilitic neuropathy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
G13.0	Paraneoplastic neuromyopathy and neuropathy
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease
G60.3	Idiopathic progressive neuropathy
G60.8	Other hereditary and idiopathic neuropathies
G60.9	Hereditary and idiopathic neuropathy, unspecified
G61.1	Serum neuropathy
G61.81	Chronic inflammatory demyelinating polyneuritis
G62.0	Drug-induced polyneuropathy
G62.2	Polyneuropathy due to other toxic agents
G62.82	Radiation-induced polyneuropathy
G63	Polyneuropathy in diseases classified elsewhere
G65.0	Sequelae of Guillain-Barre syndrome
G65.1	Sequelae of other inflammatory polyneuropathy
G65.2	Sequelae of toxic polyneuropathy
M05.511	Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder
M05.512	Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder
M05.519	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder
M05.521	Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow
M05.522	Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow
M05.529	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow
M05.531	Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist
M05.532	Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist
M05.539	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist
M05.541	Rheumatoid polyneuropathy with rheumatoid arthritis of right hand

ICD-10 CODE	DESCRIPTION
M05.542	Rheumatoid polyneuropathy with rheumatoid arthritis of left hand
M05.549	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand
M05.551	Rheumatoid polyneuropathy with rheumatoid arthritis of right hip
M05.552	Rheumatoid polyneuropathy with rheumatoid arthritis of left hip
M05.559	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip
M05.561	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee
M05.562	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee
M05.569	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee
M05.571	Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
M05.572	Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
M05.579	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot
M05.59	Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites
M34.83	Systemic sclerosis with polyneuropathy

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
021x	Skilled Nursing - Inpatient (Including Medicare Part A)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/27/2019	R5	Under **CPT/HCPCS Codes Group 1: Paragraph** deleted the verbiage "Note: NCD 150.10 prohibits payment for individuals over 60 years of age for the following CPT® /HCPCS code: **22862.** Palmetto GBA has also determined this code does not meet medically necessary criteria for individuals under 60 years of age." Under **CPT/HCPCS Codes Group 1: Codes** deleted CPT® codes 22858 and 22861.
10/10/2019	R4	This article is being revised in order to adhere to CMS requirements per chapter 13, section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. Regulations regarding billing and coding were removed from the **CMS National Coverage Policy** section of the related Noncovered Services other than CPT® Category III Noncovered Services L36954 LCD and placed in this article. Under **Article Text** deleted the subheading **Associated Information**.
05/23/2019	R3	Under **Article Text** added the subheading "Coverage Indications, Limitations and/or Medical Necessity" and the corresponding verbiage: Although a payment amount for a particular service may appear in the Medicare fee schedule, this listing alone does not guarantee Medicare coverage or reimbursement for that service. The presence of a payment amount in the Medicare Physician Fee Schedule (MPFS) and the Medicare Physician Fee Schedule Database (MPFSDB) does not imply that the Centers for Medicare and Medicaid (CMS) has determined that the service is covered by Medicare. The only status indicator that influences coverage is N, which indicates a non-covered service. A Medicare Administrative Contractor (MAC) may determine whether a service is reasonable and necessary. If a service is determined not to be reasonable and necessary, MACs may consider the service to be non-covered. **It is also important to note that when a new service or procedure has been issued a CPT® code or is FDA approved for a specific indication; that does not in itself render the procedure (or the device which has received FDA approval) medically reasonable and necessary. Palmetto GBA evaluates new services, procedures, drugs or technology based on peer-reviewed literature, the results of clinical trials, etc., and considers national and local policies before these new services may be accepted as Medicare covered services in Jurisdiction J and M in the absence of a specific coverage decision issued by CMS.** This article contains listings of numerous non-covered services which have no specific CPT® code. In some instances there exists two or more unlisted codes that could

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		arguably be used to designate the service. In such cases, the absence of a code from this article does not guarantee that the service billed will be covered when billed under a different code. **Therefore**, providers must bear in mind that **any** service that is described in any Palmetto GBA LCD or article as "non-covered" will remain non-covered no matter which CPT® code is selected for billing. Occasionally when a service is billed with an unlisted code it may be unclear as to exactly what service was supplied and a payment may be made in error for a noncovered service. Providers are reminded that these paid services will be subject to recoupment by Palmetto GBA, as well as other review contractors, including the Recovery Auditors (RAs), Zone Program Integrity Contractors (ZPICs), etc. Services that this contractor considers a component of another service and never separately billable or payable are also included here unless those services are already included in the mutually exclusive Correct Coding Initiative (CCI) edits implemented by CMS. For some services, one or more of the Medicare payment systems (for example, the MPFS or the Outpatient Prospective Payment System (OPPS)) may indicate that the service is bundled or packaged or not paid for some other reason, in which case those indicators take precedence over the placement in this article. **List of (bundled) components that are not separately billable to the Contractor or the Beneficiary:** • Allergy - AG prep • Anesthesia intravenous (IV) start or intubation • Angiojet thrombectomy any artery or vein • Application/instillation of mitomycin • Cast mold • CorMatrix • Coronary sinus venography • Embolic protection device • Eye retractor advancement • GliaSite® balloon placement • Implantation/placement of antibiotic beads • Implantation of Doppler device • Intrapericardial defibrillator coil • Intraoperative blood flow measurement • ON-Q® pain pump placement and/or management • Pentacam® • Peripherally inserted central catheter (PICC) removal (when billed by same provider) • Pin fixation • Pope earwick • Potential acuity meter • Propel® sinus implant • Pump catheter placement • Pupillography or measure of alertness by pupillometry • Resection/ligation of atrial appendage • Schirmer test (ophthalmic mucous membrane test) • Stat fee • Stryker pain pump insertion • Suture removal (when billed by same provider) • Symphony system for procedure • Two week home auto continuous positive airway pressure (CPAP) titration study • Ultrasound (US) guidance for fiducial marker placement • Via modem transmission telemedicine • Visiometer testing The content of this article is not an all-inclusive list of non-covered services or those services not paid separately by Medicare. This article post-dates existing LCDs and articles that address specific non-covered services that may not be repeated within this article. Compliance with the provisions in this article is subject to monitoring by post payment data analysis and subsequent medical review which may result in recoupment of Medicare payments.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
05/05/2019	R2	Under **CPT/HCPCS Codes Group 1: Codes** deleted CPT® code 22862. CPT® code 22858 was added as it was inadvertently deleted.
05/05/2019	R1	All coding located in the **Coding Information** section has been removed from the related Noncovered Services other than CPT® Category III Noncovered Services L36954 LCD and added to this article. Under **CPT/HCPCS Codes Group 1: Codes** deleted 22857 and 22858.

Associated Documents

Related Local Coverage Document(s)

LCD(s)
L36954 - Noncovered Services other than CPT® Category III Noncovered Services

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

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Keywords

- Noncovered Services