Benefit Coverage

Covered Benefit for lines of business including:
Covered Benefit for lines of business including: For Medicare-Medicaid Plan (MMP) Integrity **Only**
Excluded from Coverage:
Extended Family Planning (EFP), Health Benefits Exchange (HBE), Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE)

Description:
The American Medical Association developed CATEGORY III codes to allow for data collection concerning the use of "emerging technologies, services, and procedures." The creation of these codes neither implies nor endorses clinical efficacy, safety or the applicability to clinical practice.

Coverage Determination/Documentation:
The patient's medical record must contain documentation that fully supports the medical necessity for CATEGORY III CPT codes as they are covered by Medicare.

This documentation includes but is not limited to:

- ☐ relevant history
- ☐ physical examination
- ☐ results of pertinent diagnostic tests or procedures and
- ☐ any other records that describe or support the evaluation and treatment of the patient.

1. **(CPT 0075T) - Transcatheter placement of extracranial vertebral artery stent(s)**, including radiologic supervision and interpretation, open or percutaneous; initial vessel.
    - 0076T- Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)
    - Note: These codes are allowed when provided in accordance with NCD 20.7, Percutaneous Transluminal Angioplasty.

2. **(CPT 0100T)- Placement of a subconjunctival retinal prosthesis receiver and pulse generator**, and implantation of intra-ocular retinal electrode array, with vitrectomy.

3. **(CPT 0184T): Transanal Endoscopic Microsurgery (TEM)** TEM is a minimally invasive surgical procedure that presents an alternative to laparoscopic surgical excision or open surgical excision for mild and proximally located rectal benign and selected malignant lesions. TEM is considered medically necessary for patients who have one of the following conditions:
    - Benign rectal tumors (adenomas)

- Malignant tumors less than 3cm in size, well to moderately differentiated, early stage Tis or T1N0, within 8cm of the anal verge, less than 30% of the rectal circumference, and it can be removed with clear margins.
- Small rectal carcinoids less than 2cm in diameter.
- Are medically unfit or unwilling to undergo a radical resection and require palliative resection.

TEM is considered not medically necessary for all other indications because its effectiveness for any other indications has not been established.

4. **(CPT 0191T)- Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion.**
   - 0376T- Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)
   - 0474T-Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space.

   LCD L37244 LCD L35490

5. **(CPT 0249T): Ligation, Hemorrhoidal Vascular Bundle(s) including Ultrasound Guidance** NGS will allow services for Doppler-guided hemorrhoid artery ligation with or without mucopexy for Grade II or III hemorrhoids that have failed rubber band ligation or conservative treatment (behavior modification, high fiber diets to control constipation, and hydrocortisone cream or suppositories).

6. **(CPT 0275T): Percutaneous Image-Guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis** CMS has determined that PILD will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) through Coverage with Evidence Development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study.

7. **(CPT 0295T, 0296T, 0297T, 0298T): External Electrocardiographic Recording** (more than 48 hours and up to 21 days) This service, when performed by continuous rhythm recording and storage will be allowed for the same indications as dynamic electrocardiography (e.g. Holter monitoring) codes.8.
   - (CPT 0308T)- Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis

8. **(CPT 0394T)- High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry,** when performed.
   - 0395T- High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed
9. (CPT 0308T) – Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis. This code is billable with the covered (authorization required code) C1840 Lens, intraocular telescopic. See LCD l35490 and LCD L33584.

Exclusions:

Any category III code that is not mentioned above or provided for any indications not mentioned in the above criteria are considered non-covered.

Authorization Forms

Please access Prior Authorization forms by visiting Neighborhood's website at www.nhpri.org

1. Go to the section for Providers
2. Click on "Resources & FAQ's"
3. Click on "Medical Management Request Forms"- forms are listed alphabetically by program.

Prior Authorization Forms

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060.

Fax authorization forms to 401-459-6023.

Covered Codes: For information on Coding please reference the Authorization Quick Reference Guide

CMP Cross Reference:

Local Coverage Determination: Category III CPT Codes (L33392)

Local Coverage Determination Category III CPT Codes (L35490)

Created:	2/17/16
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CMO Approval Dates:	3/22/17, 4/12/18
Effective Date:	7/1/16, 3/23/17, 4/12/18

Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

References:

National Coverage Determination for Percutaneous image-guided lumbar decompression for lumbar spinal stenosis (150.13)

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line-401-459-6060. Authorization Fax- 401-459-6023