Molina Clinical Policy
Category III CPT Codes: Policy No. 321

Last Approval: 12/13/2023
Next Review Due By: December 2024

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Current Procedural Terminology (CPT) Category III codes are developed by the American Medical Association (AMA) and are defined as a set of temporary codes for emerging technology, services, procedures, and service paradigms. Category III codes enable the collection of data for these services or procedures. If a Category III code is available, this code must be reported rather than a Category I unlisted code. The use of these codes allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, procedures, and service paradigms for clinical efficacy, utilization, and outcomes.

The inclusion of a service or procedure as a Category III code does not constitute a finding of support, or lack thereof, regarding clinical efficacy, safety, applicability to clinical practice, or payer coverage. These codes may not conform to the usual requirements for CPT Category I codes established by the AMA. For Category I codes, the AMA requires that the service/procedure be performed by many health care professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. The nature of emerging technology, services, procedures, and service paradigms is such that these requirements may not be met. For these reasons, temporary codes for emerging technology, services, procedures, and service paradigms have been placed in a separate section of the CPT code set, and the codes are differentiated from Category I CPT codes using alphanumeric characters (e.g., four digits followed by the letter T).

Section 1862(a)(1)(A) of the Social Security Act (SSA) (AMA 2023) is the statutory 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 by the medical community as safe and effective in the setting and for the condition for which it is used;
- Not proven safe and effective based on peer review or scientific literature;
- Experimental;
- Not medically necessary for a particular patient;
- Furnished at a level, duration, or frequency that is not medically 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 medically necessary. That is, the items and services must be:

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

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Medical devices that are not approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not considered reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures and services performed using devices that have not been approved for marketing by the FDA or for those not included in an FDA-approved investigational device exemption (IDE) trial.

COVERAGE POLICY

Molina Healthcare considers all services and procedures listed in the current and future Category III CPT code list **as experimental, investigational, and unproven*** except when there is a specific Centers for Medicare and Medicaid Services (CMS) National or Local Coverage Determination (NCD or LCD), state guidance, Molina Clinical Policy, or an MCG Guideline that addresses medically necessary indications for the specific category III CPT code.

**Reference MCP-184 Experimental and Investigational Services for definition of experimental, investigational, and unproven services.*

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

There are no published guidelines or recommendations by national/professional societies and organizations.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

Codes	Code Description
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each
0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function
0692T	Therapeutic ultrafiltration

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0699T	Injection, posterior chamber of eye, medication
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)
0708T	Intradermal cancer immunotherapy; preparation and initial injection
0709T	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming
0731T	Augmentative AI-based facial phenotype analysis with report
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (e.g., CT, MRI, or myocardial perfusion scan) and electrical data (e.g., 12-lead ECG data), and identification of areas of avoidance
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD
0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
0752T	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
0755T	Digitization of glass microscope slide for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
0756T	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (e.g., acid fast, methenamine silver) (List separately in addition to code for primary procedure)
0757T	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (e.g., iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)
0758T	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)
0759T	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)
0760T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)
0761T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)
0762T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)
0763T	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)

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0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (e.g., vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment
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
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment
0791T	Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)
0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately
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)
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)
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)
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)
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
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)
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)
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

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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)
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation, and report
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation, and report
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed (Effective 01/01/2024)
0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator (Effective 01/01/2024)
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed (Effective 01/01/2024)
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator (Effective 01/01/2024)
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters (Effective 01/01/2024)
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters (Effective 01/01/2024)
0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed (Effective 01/01/2024)
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous (Effective 01/01/2024)
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial (Effective 01/01/2024)
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous (Effective 01/01/2024)
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial (Effective 01/01/2024)
0859T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure) (Effective 01/01/2024)
0860T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities (Effective 01/01/2024)

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

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APPROVAL HISTORY

12/13/2023	Policy reviewed, no changes to criteria. Updated Overview, Coding and Billing, and References.
12/14/2022	Policy revised. Coverage Policy section: Removed 'Molina Clinical Review (MCR)' and added 'MCG Care Guidelines.' Removed table of CPT code ranges. Inserted T-code table, including codes and T-code description.
04/13/2022	Policy reviewed, no changes to coverage criteria, updated CPT codes.
04/05/2021	Policy reviewed, no changes.
04/23/2020	Policy reviewed, no changes.
09/18/2019	Policy reviewed, no changes.
07/10/2018	New policy.

REFERENCES

1. American Medical Association (AMA). Category III codes. Updated June 30, 2023. Accessed November 17, 2023. https://www.ama-assn.org/practice-management/cpt/category-iii-codes.
2. Centers for Medicare and Medicaid Services (CMS). Medicare coverage database (search: category III CPT® codes, L35490). Accessed November 17, 2023. https://www.cms.gov/medicare-coverage-database/search.aspx.
3. Centers for Medicare and Medicaid Services (CMS). Billing and coding: Category III codes (article A56902). Accessed November 8, 2023. https://www.cms.gov/medicare-coverage-database/search.aspx.
4. Optum360. EncoderPro Current Procedural Terminology (CPT®), professional edition: American Medical Association AMA CPT® section guidelines on category III codes. Accessed November 17, 2023. https://www.optumcoding.com/.

APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

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