

MEDICAL POLICY – 2.01.40

Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions

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RELATED MEDICAL POLICIES:

1.01.05 Low Intensity Pulsed Ultrasound Fracture Healing Device

7.01.07 Electrical Bone Growth Stimulation of the Appendicular Skeleton

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Introduction

Extracorporeal is a term that means outside of the body. Extracorporeal shockwave therapy uses shock waves to try to treat conditions affecting bone and tissues. There are two forms of this treatment, low-energy and high-energy. It's believed that the shock waves create small amounts of damage to the tissues being treated. The body then responds by creating new blood vessels and sending more nutrients to the area. This natural healing response is thought to affect the condition being treated. The low-energy treatments might need no or only mild anesthesia. The high-energy shock wave treatments often require general anesthesia or a block to stop the pain in a particular area. The effectiveness of this treatment is in question. More medical studies are needed to determine if shock wave therapy is effective.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Therapy	Investigational
Extracorporeal shock wave therapy (ESWT)	<p>Extracorporeal shock wave therapy (ESWT), using either a high- or low-dose protocol or radial ESWT, is considered investigational as a treatment of musculoskeletal conditions, including but not limited to:</p> <ul style="list-style-type: none"> • Achilles tendinitis • Avascular necrosis of the femoral head • Delayed union and nonunion of fractures • Patellar tendinitis • Plantar fasciitis • Spasticity • Stress fractures • Tendinitis of the elbow (lateral epicondylitis) • Tendinopathies including tendinitis of the shoulder

Coding

High-energy ESWT requires the use of anesthesia and is performed in a hospital or ambulatory surgery center. Low-energy ESWT is usually used in the office without anesthesia.

Code	Description
CPT	
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified
0102T	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle
28890	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information



Benefit Application

Extracorporeal shock wave treatment for plantar fasciitis may be performed by podiatrists, orthopedic surgeons, and primary care physicians.

Evidence Review

Description

Extracorporeal shock wave therapy (ESWT) is a noninvasive method used to treat pain with shock or sound waves directed from outside the body onto the area to be treated (e.g., the heel in the case of plantar fasciitis). Shock waves are generated at high- or low-energy intensity, and treatment protocols can include more than one treatment. ESWT has been investigated for use in a variety of musculoskeletal conditions.

Background

Chronic Musculoskeletal Conditions

Chronic musculoskeletal conditions (e.g., tendinitis) can be associated with a substantial degree of scarring and calcium deposition. Calcium deposits may restrict motion and encroach on other structures, such as nerves and blood vessels, causing pain and decreased function. One hypothesis is that disruption of calcific deposits by shock waves may loosen adjacent structures and promote resorption of calcium, thereby decreasing pain and improving function.

Plantar Fasciitis

Plantar fasciitis is a common ailment characterized by deep pain in the plantar aspect of the heel, particularly on arising from bed. While the pain may subside with activity, in some individuals the pain persists, interrupting activities of daily living. On physical examination, firm pressure will elicit a tender spot over the medial tubercle of the calcaneus. The exact etiology of plantar fasciitis is unclear, although repetitive injury is suspected. Heel spurs are often a common associated finding, although it is unproven that heel spurs cause the pain. Asymptomatic heel spurs can be found in up to 10% of the population.



Tendinitis and Tendinopathies

Common tendinitis and tendinopathy syndromes are summarized in [Table 1](#). Many tendinitis and tendinopathy syndromes are related to overuse injury.

Table 1: Tendinitis and Tendinopathy Syndromes

Disorder	Location	Symptoms	Conservative Therapy	Other Therapies
Lateral epicondylitis (elbow tendinitis/ "tennis elbow")	Lateral elbow (insertion of wrist extensors)	Tenderness over lateral epicondyle and proximal wrist extensor muscle mass; pain with resisted wrist extension with the elbow in full extension; pain with passive terminal wrist flexion with the elbow in full extension	<ul style="list-style-type: none"> • Rest • Activity modification • NSAIDs • Physical therapy • Orthotic devices 	Corticosteroid injections; joint débridement (open or laparoscopic)
Shoulder tendinopathy	Rotator cuff muscle tendons, most commonly supraspinatus	Pain with overhead activity	<ul style="list-style-type: none"> • Rest • Ice • NSAIDs • Physical therapy 	Corticosteroid injections
Achilles tendinopathy	Achilles tendon	Pain or stiffness 2-6 cm above the posterior calcaneus	<ul style="list-style-type: none"> • Avoidance of aggravating activities • Ice when symptomatic • NSAIDs • Heel lift 	Surgical repair for tendon rupture
Patellar tendinopathy ("jumper's knee")	Proximal tendon at lower pole of the patella	Pain over anterior knee and patellar tendon; may progress to tendon calcification and/or tear	<ul style="list-style-type: none"> • Ice • Supportive taping • Patellar tendon straps • NSAIDs 	

NSAIDs: nonsteroidal anti-inflammatory drugs



Fracture Nonunion and Delayed Union

The definition of a fracture nonunion remains controversial, particularly the duration necessary to define nonunion. One proposed definition is a failure of progression of fracture healing for at least 3 consecutive months (and at least 6 months after the fracture) accompanied by clinical symptoms of delayed/nonunion (pain, difficulty weight bearing). The following criteria to define nonunion were used to inform this policy:

- At least 3 months since the date of fracture;
- Serial radiographs have confirmed that no progressive signs of healing have occurred;
- The fracture gap is 1 cm or less; and
- The individual can be adequately immobilized and is of an age likely to comply with non-weight bearing limitation.

The delayed union can be defined as a decelerating healing process, as determined by serial radiographs, together with a lack of clinical and radiologic evidence of union, bony continuity, or bone reaction at the fracture site for no less than 3 months from the index injury or the most recent intervention. (In contrast, nonunion serial radiographs show no evidence of healing.)

Other Musculoskeletal and Neurologic Conditions

Other musculoskeletal conditions include medial tibial stress syndrome, osteonecrosis (avascular necrosis) of the femoral head, coccydynia, and painful stump neuromas. Neurologic conditions include spasticity, which refers to a motor disorder characterized by increased velocity-dependent stretch reflexes. It is a characteristic of upper motor neuron dysfunction, which may be due to a variety of pathologies.

Treatment

Most cases of plantar fasciitis are treated with conservative therapy, including rest or minimization of running and jumping, heel cups, and nonsteroidal-anti-inflammatory drugs. Local steroid injection may also be used. Improvement may take up to one year in some cases.

For tendinitis and tendinopathy syndromes, conservative treatment often involves rest, activity modifications, physical therapy, and anti-inflammatory medications (see [Table 1](#)).



Extracorporeal Shock Wave Therapy

Also known as orthotripsy, ESWT has been available since the early 1980s for the treatment of renal stones and has been widely investigated for the treatment of biliary stones. ESWT uses externally applied shock waves to create a transient pressure disturbance, which disrupts solid structures, breaking them into smaller fragments, thus allowing spontaneous passage and/or removal of the stones. The mechanism by which ESWT might have an effect on musculoskeletal conditions is not well-defined.

Other mechanisms are also thought to be involved in ESWT. Physical stimuli are known to activate endogenous pain control systems, and activation by shock waves may “reset” the endogenous pain receptors. Damage to endothelial tissue from ESWT may result in increased vessel wall permeability, causing increased diffusion of cytokines, which may, in turn, promote healing. Microtrauma induced by ESWT may promote angiogenesis and thus aid healing. Finally, shock waves have been shown to stimulate osteogenesis and promote callous formation in animals, which is the basis for trials of ESWT in delayed union or nonunion of bone fractures.

There are two types of ESWT: focused and radial. Focused ESWT sends medium- to high-energy shockwaves of single pressure pulses lasting microseconds, directed on a specific target using ultrasound or radiographic guidance. Radial ESWT (RSW) transmits low- to medium-energy shockwaves radially over a larger surface area. The US Food and Drug Administration (FDA) approval was first granted in 2002 for focused ESWT devices and in 2007 for RSW devices.

Summary of Evidence

For treatment of plantar fasciitis using ESWT, numerous randomized controlled trials (RCTs) were identified, including several well-designed double-blinded RCTs, that evaluated ESWT for the treatment of plantar fasciitis. Several systematic reviews and meta-analyses have been conducted, covering numerous studies, including studies that compared ESWT with corticosteroid injections. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Pooled results were inconsistent. Some meta-analysis reported that ESWT reduced pain, while others reported nonsignificant pain reduction. Reasons for the differing results included lack of uniformity in the definitions of outcomes and heterogeneity in ESWT protocols (focused vs radial, low- vs high-intensity/energy, number and duration of shocks per treatment, number of treatments, and differing comparators). Some studies reported significant benefits in pain and functional improvement at three months, but it



is not evident that the longer-term disease natural history is altered with ESWT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have lateral epicondylitis who receive ESWT, the most direct evidence on the use of ESWT to treat lateral epicondylitis comes from multiple small RCTs. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. The RCTs did not consistently show outcome improvements beyond those seen in control groups. The highest quality trials tend to show no benefit, and systematic reviews have generally concluded that the evidence does not support a treatment benefit over placebo or no treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have shoulder tendinopathy who receive ESWT, a number of small RCTs, summarized in several systematic reviews and meta-analyses, comprise the evidence. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Network meta-analyses focused on three outcomes: pain reduction, functional assessment, and change in calcific deposits. One network meta-analysis separated trials using high-energy focused shock wave (H-FSW), low-energy focused shock wave, and radial shock wave (RSW). This analysis reported the most effective treatment for pain reduction was ultrasound-guided needling, followed by RSW and H-FSW. The only treatment showing a benefit in functional outcomes was H-FSW. For the largest change in calcific deposits, the most effective treatment was ultrasound-guided needling, followed by RSW and H-FSW. Although some trials have reported a benefit for pain and functional outcomes, particularly for high-energy ESWT for calcific tendinopathy, many available trials have been considered poor quality. For non-calcific tendinopathy, 1 meta-analysis found that ESWT exhibited a small improvement in shoulder pain compared to sham ESWT at short-term follow-up (≤ 3 months). However, ESWT was not superior to sham ESWT in improving function at short- or long-term follow up (≥ 12 months), and ESWT was not superior to other treatments. More high-quality trials are needed to determine whether ESWT improves outcomes for shoulder tendinopathy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Achilles tendinopathy who receive ESWT, the evidence includes systematic reviews of RCTs, and RCTs published after the systematic review. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In the most recent systematic review, a pooled analysis reported that ESWT reduced both short- and long-term pain compared with nonoperative treatments, although reviewers warned that results were inconsistent across the RCTs and that there was



heterogeneity across patient populations and treatment protocols. An RCT published after the systematic review compared ESWT with hyaluronan injections and reported improvements in both treatment groups, although the improvements were significantly higher in the injection group. Another RCT found no difference in pain scores between low-energy ESWT and sham controls at week 24, but ESWT may provide short therapeutic effects at weeks 4 to 12. Another RCT found scores were statistically and clinically improved with ESWT compared with sham control at one month and 16 months on measures of pain and function. The most recent RCT found that activity-related pain was lower with ESWT at 6 weeks compared to ultrasound therapy, but there was no difference in pain at rest. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have patellar tendinopathy who receive ESWT, the evidence includes systematic reviews and RCTs. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Systematic reviews and trials have reported inconsistent results and were heterogeneous in treatment protocols and lengths of follow-up. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have medial tibial stress syndrome who receive ESWT, the evidence includes a small RCT and a small nonrandomized cohort study. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. The RCT reported no difference in self-reported pain measurements between study groups. The nonrandomized trial reported improvements with ESWT, but selection bias limited the strength of the conclusions. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have osteonecrosis of the femoral head who receive ESWT, the evidence includes systematic reviews of small, mostly nonrandomized studies. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Many of the studies were low quality and lacked comparators. While most studies reported favorable outcomes with ESWT, limitations such as heterogeneity in the treatment protocols, patient populations, and lengths of follow-up make conclusions on the efficacy of ESWT for osteonecrosis uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have nonunion or delayed union who receive ESWT, the evidence includes systematic reviews, relatively small RCTs with methodologic limitations (e.g., heterogeneous outcomes and treatment protocols), and case series. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. The available evidence does not permit conclusions on the efficacy of ESWT in fracture nonunion,



delayed union, or acute long bone fractures. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have spasticity who receive ESWT, the evidence includes RCTs and systematic reviews, primarily in individuals with stroke and cerebral palsy. The relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Several studies have demonstrated improvements in spasticity measures after ESWT, but most studies have small sample sizes and single center designs. More well-designed controlled trials in larger populations are needed to determine whether ESWT leads to clinically meaningful improvements in pain and/or functional outcomes for spasticity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this policy are listed in [Table 2](#).

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06128616	Efficacy of Extracorporeal Shock Wave Therapy in Children With Cerebral Palsy	40	Sept 2024
NCT05883020	Effect of Radial Shockwave on Calf Muscle Spasticity in Patients With Cerebral Palsy	50	March 2024
NCT06076239	Effect of Extracorporeal Shock Wave Therapy in Impingement Syndrome (ESWT)	32	June 2022
NCT06329154	Clinical Study On Extracorporeal Shock Wave Therapy For Rotator Cuff Injuries	58	Feb 2025
NCT04316026	Effectiveness of Shock Wave Therapy to Treat Upper Limb Spasticity in Hemiparetic Patients	48	Jun 2024
NCT02546128	LEICSTES=LEICeSter Tendon Extracorporeal Shock Wave Studies Assessing the Benefits of the Addition of Extracorporeal Shock	720	Dec 2024



NCT No.	Trial Name	Planned Enrollment	Completion Date
	Wave Treatment to a Home-Rehabilitation Programme for Patients with Tendinopathy		
NCT04332471	Treatment of Plantar Fasciitis With Radial Shockwave Therapy vs. Focused Shockwave Therapy: a Randomized Controlled Trial	114	Mar 2025
NCT05689593	Comparison of the Efficiency of Low Intensity Extracorporeal Shock Wave Therapy and Low Intensity Laser Therapy in Adhesive Capsulitis Treatment: a Randomized Controlled Study	60	Aug 2023
NCT05405140	Multiphasic Neuroplasticity Based Training Protocol With Shock Wave Therapy For Post Stroke Spasticity	32	Oct 2023
NCT05771220	The Effect of Extracorporeal Shockwave Therapy on Adhesive Capsulitis Shoulder: A Randomized Controlled Trial	40	Jul 2023
Unpublished			
NCT03472989	The Effectiveness of Radial Extracorporeal Shockwave Therapy (rESWT), Sham-rESWT, Standardized Exercise Program or Usual Care for Patients With Plantar Fasciopathy. Study Protocol for a Double-blind, Randomized Sham-Controlled Trial	200	Feb 2023
NCT05423366	Comparative Effects of Large Focused and Controlled Unfocused (Radial) Extracorporeal Shock Wave Therapies in the Treatment of Patellar Tendinopathy	75	Dec 2022
NCT05702606	Radial Extracorporeal Shock Wave Therapy for Management of Spasticity in Patients With Cerebral Palsy	73	Oct 2022
NCT05360316	The Effect of Extracorporeal Shock Wave Therapy Applied to the Plantar Region in Individuals With Hemiplegia on Mobility, Plantar Pressure Distribution and Sensory	60	May 2021
NCT03779919	The Therapeutic Effect of the Extracorporeal Shock Wave Therapy on Shoulder Calcific Tendinitis	90	May 2020
NCT03399968	Extracorporeal Shockwave Therapy (ESWT) in Patients Suffering From Complete Paraplegia at the Thoracic Level	25	May 2020
NCT02424084	Effects of Extracorporeal Shock Wave Therapy in Bone Microcirculation	80	Feb 2023

NCT: national clinical trial.



Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Foot and Ankle Surgeons

In 2010, Thomas et al revised guidelines on the treatment of heel pain on behalf of the American College of Foot and Ankle Surgeons.⁹⁶ The guidelines identified ESWT as a third-tier treatment modality in individuals who have failed other interventions, including steroid injection. The guidelines recommended ESWT as a reasonable alternative to surgery. In an update to the American College of Foot and Ankle Surgeons clinical consensus statement, Schneider et al stated that ESWT is a safe and effective treatment for plantar fasciitis.⁹⁷

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence has published guidance on ESWT for a number of applications.

- The two guidance documents issued in 2009 stated that current evidence on the efficacy of ESWT for refractory tennis elbow and plantar fasciitis “is inconsistent.”^{98,99}
- A guidance issued in 2011 stated that evidence on the efficacy and safety of ESWT for refractory greater trochanteric pain syndrome “is limited in quality and quantity.”¹⁰⁰
- A guidance issued in 2016 stated that current evidence on the efficacy of ESWT for Achilles tendinopathy “is inconsistent and limited in quality and quantity.”¹⁰¹
- A guidance issued in 2022 stated that evidence on the efficacy of ESWT for calcific tendinopathy of the shoulder is inadequate. Despite a lack of safety concerns, the ESWT should only be used in the context of research.¹⁰²



Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Selected ESWT devices have been approved or cleared by the FDA are included in [Table 3](#).

Table 3: FDA-Approved Extracorporeal Shock Wave Therapy Devices

Device Name	Approval Date	Delivery System Type	Indication
OssaTron device (HealthTronics)	2000	Electrohydraulic delivery system	Chronic proximal plantar fasciitis, i.e., pain persisting >6 mo and not responding to conservative management Lateral epicondylitis
Epos Ultra (Dornier)	2002	Electromagnetic delivery system	Plantar fasciitis
SONOCUR Basic (Siemens)	2002	Electromagnetic delivery system	Chronic lateral epicondylitis (unresponsive to conservative therapy for >6 mo)
Orthospec Orthopedic ESWT (Medispec)	2005	Electrohydraulic spark-gap system	Chronic proximal plantar fasciitis in patients ≥ 18 y
Orbasone Pain Relief System (Orthometrix)	2005	High-energy sonic wave system	Chronic proximal plantar fasciitis in patients ≥ 18 y
Duolith SDI Shock Wave Therapy Device (Storz Medical AG)	2016	Electromagnetic delivery system	Chronic proximal plantar fasciitis in patients ≥ 18 y with a history of failed alternative conservative therapies >6 mo

FDA: US Food and Drug Administration

Both high-dose and low-dose protocols have been investigated. A high-dose protocol consists of a single treatment of high-energy shock waves (1300 mJ/mm²). This painful procedure requires anesthesia. A low-dose protocol consists of multiple treatments, spaced one week to



one month apart, in which a lower dose of shock waves are applied. This protocol does not require anesthesia. The FDA-labeled indication for the OssaTron and Epos Ultra device specifically describes a high-dose protocol, while the labeled indication for the Sonocur device describes a low-dose protocol.

In 2007, Dolorclast (EMS Electro Medical Systems), a radial ESWT, was approved by the FDA through the premarket approval process. Radial ESWT is generated ballistically by accelerating a bullet to hit an applicator, which transforms the kinetic energy into radially expanding shock waves. Radial ESWT is described as an alternative to focused ESWT and is said to address larger treatment areas, thus providing potential advantages in superficial applications like tendinopathies. The FDA-approved indication is for the treatment of individuals 18 years and older with chronic proximal plantar fasciitis and a history of unsuccessful conservative therapy.

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History

Date	Comments
06/19/01	Add to Medicine Section - New Policy
01/08/02	Replace policy - Patient criteria updated to include patient criteria, Policy statement changed to "may be considered medically necessary." Name changed to include "and Other Musculoskeletal Conditions". Policy replaces CP.MP.BC.2.01.40.
03/12/02	Replace policy - Policy updated with TEC assessments. Policy replaces CP.MP.BC.2.01.109.
08/12/03	Replace Policy - Policy replaces CP.MP.BC.2.01.40. No change to policy statement.
02/10/04	Replace Policy - Policy replaces CP.MP.PR.2.01.109. Policy updated with additional references for treatment of plantar fasciitis; policy statement is changed to investigational. Effective July 15, 2004 due to notification process.
01/11/05	Replace Policy - Policy updated with October 2004 TEC Assessments; endonitis of the elbow added to investigational status in the policy statement.
07/12/05	Replace Policy - Policy updated with CPT codes effective 7/1/05.
02/06/06	Codes updated - No other changes.
03/14/06	Replace Policy - Policy updated with additional references and information on newly approved ESWT devices; no change to policy statement.
06/16/06	Update Scope and Disclaimer - No other changes.
03/19/07	Cross Reference Update - No other changes.
10/9/07	Replace Policy - Policy updated with literature search through April 2007; no change in policy statement. References added.
02/10/09	Replace Policy - Policy updated with literature search. Policy statement updated to include radial ESWT to the investigational criteria. References added.
11/10/09	Cross Reference Update - No other changes.
02/09/10	Replace policy - Policy updated with literature search; no change to the policy statement. References added.
05/10/11	Replace Policy - Policy updated with literature search; reference numbers 37-44 added; references 13,14,16,17 and 45-48 updated. No change in policy statement. ICD-10 codes added.
04/25/12	Replace policy. Policy updated with literature search through December 2011; references 25 and 36 added and references reordered; some references removed. No change in policy statement.
08/27/12	Update Coding Section – ICD-10 codes are now effective 10/01/2014.



Date	Comments
04/16/13	Replace policy. Policy updated with literature review, references 11, 19, 20, 21, 24 added. No change to policy statements.
05/05/14	Annual Review. Policy updated with literature review through January 20, 2014. Moved details of high/low intensity therapy from the Regulatory section to the Description section. References 5-7, 24-25, 30, 34 added; others renumbered/removed. Policy statements unchanged. ICD-9 and ICD-10 diagnosis and procedure codes removed; they are not utilized in policy adjudication.
04/24/15	Annual Review. Policy updated with literature review through January 12, 2015. References 8, 15, 17, 28, 31, 34, 40, 45, 47-48, and 54-55 added. Editorial changes made for clarity to policy statements; intent of policy statements unchanged.
09/01/16	Annual Review, approved August 9, 2016. Policy updated with literature review through May 2, 2016; references 9, 28-29, and 31 added. Policy statements unchanged.
09/01/17	Annual Review, approved August 1, 2017. Policy moved into new format. Policy updated with literature review through April 25, 2017; references 5-6, 18, 27, 34-35, 41-43, 51-53, 56-58, 61, 64, and 68. Policy statement unchanged. Added CPT code 20999.
01/01/18	Coding update, removed CPT code 0019T as it was terminated 1/1/17, replaced with CPT code 20999.
08/01/18	Annual Review, approved July 25, 2018. Policy updated with literature review through April 2018; references 18, 20-22, 37, 45-46, and 79 added. Policy statement unchanged.
09/01/19	Annual Review, approved August 6, 2019. Policy updated with literature review through April 2019; references added. Policy statement unchanged.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.
06/10/20	Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.
12/01/20	Annual Review, approved November 19, 2020. Policy updated with literature review through September 2, 2020; references added. Policy statement unchanged.
09/01/21	Annual Review, approved August 3, 2021. Policy updated with literature review through April 21, 2021; references added. Policy statement unchanged.
01/01/22	Coding update, updated description for CPT 0101T & 0102T.
08/01/22	Annual Review, approved July 25, 2022. Policy updated with literature review through May 2, 2022; references added. Policy statement unchanged. Removed HCPCS 20999.
09/01/23	Annual Review, approved Aug. 7, 2023. Policy updated with literature review through April 21, 2023; references added. Policy statement unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.



Date	Comments
08/01/24	Annual Review, approved July 22, 2024. Policy updated with literature review through April 12, 2024; references added. Policy statement unchanged.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2024 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

