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MEDICAL POLICY – 7.01.595

Carpal Tunnel Release Surgical Techniques

Effective Date:	**June 5, 2026***
Last Revised:	Feb. 10, 2026
Replaces:	N/A

*This policy has been revised. Click here to view the current version.

RELATED MEDICAL POLICIES:

11.01.525 Site of Service Ambulatory Service Center (ASC) Select Surgical or Diagnostic Procedures in Adults

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | APPENDIX | HISTORY

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Introduction

Carpal tunnel syndrome is a condition caused by compression of the median nerve as it passes through the carpal tunnel in the wrist. This narrow passageway contains tendons that control finger movements, and when these tendons swell or pressure increases in the tunnel, the nerve becomes compressed. This leads to symptoms such as pain, tingling, numbness, and weakness in the hand, particularly in the thumb, index, and middle fingers. Often associated with repetitive hand motions, carpal tunnel syndrome can significantly impact daily activities and quality of life. Treatment options range from rest and wrist braces to surgical interventions for severe cases. This policy describes when treatments for carpal tunnel syndrome may be considered medically necessary.

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

We will review for medical necessity this elective diagnostic procedure.

We also will review the site of service for medical necessity. Site of service is defined as the location where the diagnostic or surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center.

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
Medically necessary sites of service: • **Ambulatory surgical center**	**Certain elective diagnostic or surgical procedures will be covered in the most appropriate, safe, and cost-effective site. This is the preferred medically necessary site of service for certain elective diagnostic or surgical procedures.**

• **Off campus-outpatient hospital/medical center**
• **On campus-outpatient hospital/medical center**
	Certain elective diagnostic or surgical procedures will be covered in the most appropriate, safe, and cost-effective site. An elective diagnostic or surgical procedure performed in a hospital outpatient department may be considered medically necessary if there is no access to an ambulatory surgical center due to one of the following criteria:
	• There is no qualifying ASC within 30 miles that can provide the necessary care due to one of the following:
	  ○ There is no geographically accessible ASC that has the necessary equipment to perform the procedure; or
	  ○ There is no geographically accessible ASC available at which the individual's physician has privileges; or
	  ○ An ASC's specific guideline prohibits the use of the ASC related to the individual's health condition or weight, or
	• Individual is aged 18 or younger, or
	• The service being performed is in conjunction with an additional service that requires the use of a hospital outpatient department, and the procedures are being performed in the same operative session
	OR

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
	• Individual has a clinical condition which puts them at increased risk for complications including any of the following (this list may not be all inclusive): ○ **Anesthesia Risk** ▪ ASA classification III or higher (see definition) ▪ Personal history of complication of anesthesia ▪ Documentation of alcohol dependence or history of cocaine use ▪ Prolonged surgery (Greater than3 hours) ○ **Cardiovascular Risk** ▪ Uncompensated chronic heart failure (NYHA class III or IV) ▪ Recent history of myocardial infarction (MI) (Less than 3 months) ▪ Poorly controlled, resistant hypertension* ▪ Recent history of cerebrovascular accident (Less than 3 months) ▪ Increased risk for cardiac ischemia (drug eluting stent placed less than 1 year or angioplasty less than 90 days) ▪ Symptomatic cardiac arrhythmia despite medication ▪ Significant valvular heart disease ○ **Liver Risk** ▪ Advanced liver disease (MELD Score greater than 8)** ○ **Pulmonary Risk** ▪ Chronic obstructive pulmonary disease (COPD) (FEV1 less than 50%) ▪ Poorly controlled asthma (FEV1 less than 80% despite treatment) ▪ Moderate to severe obstructive sleep apnea (OSA)*** ○ **Renal Risk** ▪ End stage renal disease (on dialysis) ○ **Other** ▪ Morbid obesity (BMI greater or equal to 50) ▪ Pregnancy

Site of Service for Elective Diagnostic or Surgical Procedures	Medical Necessity
	▪ Bleeding disorder (requiring replacement factor, blood products, or special infusion product [DDAVP**** does not meet this criterion]) ▪ Anticipated need for transfusion(s) **Note**: * 3 or more drugs to control blood pressure ** https://reference.medscape.com/calculator/meld-score-end-stage-liver-disease *** Moderate-AHI greater or equal to 15 and less than or equal to 30, Severe-AHI greater or equal to 30 ****DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)
• **Off campus-outpatient hospital/medical center** • **On campus-outpatient hospital/medical center**	**These sites of service are considered not medically necessary for certain elective diagnostic or surgical procedures when the site of service criteria listed above are not met.**
• **Inpatient hospital/medical center**	**This site of service is considered not medically necessary for this elective diagnostic or surgical procedure**

Service	Medical Necessity
Carpal tunnel release surgery • **Endoscopic** • **Open**	**Carpal tunnel release surgery (endoscopic or open) may be considered medically necessary when ALL of the following criteria are met:** • Documentation supports a clinical diagnosis of carpal tunnel syndrome in EITHER of the following situations: **Electrodiagnostic testing (e.g. nerve conduction study, electromyography) confirms carpal tunnel syndrome OR** ○ The individual has a Carpal Tunnel Symptom Scale (CTS)-6 evaluation tool score of greater than 12 (See **Related Information**) **AND** • Symptoms have not responded to at least 6 weeks of conservative treatment, including ONE or more of the following: ○ Hand immobilization (splint or brace) at night

Service	Medical Necessity
	○ Carpal tunnel corticosteroid injection **Note**: Six weeks of conservative treatment is not required if there is thenar wasting, an impaired two point discrimination test on the thumb side of the hand (radial), or other severe carpal tunnel symptoms are present **Repeat carpal tunnel release surgery (endoscopic or open) may be considered medically necessary following failure of a previous carpal tunnel release surgery.** **Carpal tunnel release surgery (endoscopic or open) is considered not medically necessary when the above criteria have not been met.**

Service	Investigational
• **Thread carpal tunnel release (TCTR)** • **US-guided percutaneous needle release (PCTR)** • **US-guided percutaneous intracarpal tunnel balloon dilation release**	**The following surgical techniques are considered investigational for the treatment of carpal tunnel syndrome:** • Thread carpal tunnel release (TCTR) • Ultrasound-guided percutaneous needle release (PCTR) (See **Appendix**) • Ultrasound-guided percutaneous intracarpal tunnel balloon dilation release

Documentation Requirements

The patient's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:
• Office visit notes contain:
  ○ Electrodiagnostic testing results that show carpal tunnel syndrome, **OR**
  ○ CTS-6 score greater than 12
AND
• Symptoms have not responded to at least 6 weeks of conservative care, including **ONE** or more of the following:
  ○ Hand immobilization (splint or brace) at night
  ○ Carpal tunnel corticosteroid injection

Coding

Code	Description
CPT	
25999	Unlisted procedure, forearm or wrist
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
64999	Unlisted procedure, nervous system
64728	Decompression; median nerve at the carpal tunnel, percutaneous with intracarpal tunnel balloon dilation, including ultrasound guidance (new code effective 01/01/26)

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

Definition of Terms

American Society of Anesthesiologists (ASA) Physical Status Classification

ASA PS Classification	Definition	Adult Examples including, but not limited to
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.

ASA PS Classification	Definition	Adult Examples including, but not limited to
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

DM-diabetes mellitus, HTN-hypertension, COPD-chronic obstructive pulmonary disease, ESRD-end stage renal disease, MI-myocardial infarction, CVA-cerebral vascular accident, TIA-transient ischemic attack, CAD-coronary artery disease, DIC-disseminated intravascular coagulation, ARD-acute respiratory distress

Source: **Statement on ASA Physical Status Classification System**. Accessed January 20, 2026

New York Heart Association (NYHA) Classification:

Class I No symptoms and no limitation in ordinary physical activity, e.g., shortness of breath when walking, climbing stairs etc.
Class II Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
Class III Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g., walking short distances (20–100 m). Comfortable only at rest.
Class IV Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients.

Phalen's test: a physical examination maneuver used to diagnose carpal tunnel syndrome. The examiner has the individual sit with their forearms resting on a table. The individual flexes both wrists, pressing the backs of their hands together, holding it for 30-60 seconds. The test is considererd positive if the individual experiences, numbness, tingling, or pain in the thumb, index, middle and thumb-side of the ring finger during the test.

Place of Service (Professional Claims Codes):

Off-Campus-Outpatient Hospital A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 19)

Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. (Code 21)

On Campus-Outpatient Hospital A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 22)

Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. (Code 24)

Thenar wasting: is the atrophy or "shrinking" of the muscles in the fleshy part of the thumb's base (thenar eminence). This occurs due to chronic, severe compression of the median nerve within the carpal tunnel causing these muscles to weaken and for the thumb pad to be visibly smaller. This can lead to decreased strength in the thumb especially when pinching or gripping and loss of function in the hand.

Tinel's sign: a healthcare provider taps on the median nerve in the wrist. The presence of a tingling or "pins and needles" sensation in the thumb, index finger, middle finger, or thumb-side of the ring finger indicates a positive test for median nerve compression related to carpal tunnel syndrome.

Two point discrimination test: measures the smallest distance at which an individual can distinguish between two points of contact on the skin. Using a paper clip, calipers, or a 2-point discrimator a healthcare professional applies two points of a device to the skin of the affected hand's fingers, randomly alternating between one and two points while the individual's eyes are closed. The individual reports feeling one or two points and the smallest distance at which the

individual consistently perceives two distinct stimuli is recorded as their two point discriminator threshold. An elevated threshold (over 4-10 mm) or the inability to distinguish two points at a given distance indicates impaired sensation due to nerve damage, which is common in carpal tunnel syndrome.

Items and Scoring of the CTS-6 Evaluation Tool:

Symptoms and history		Score
1.	**Numbness predominantly or exclusively in the median nerve territory** Sensory symptoms are mostly in the thumb, index, middle and/or ring fingers	**3.5**
2.	**Nocturnal numbness** Symptoms are predominantly the patient sleep; numbness wakes patient from sleep	**4**
Physical Examination		
3.	**Thenar atrophy and/or weakness** The bulk the thenar area is reduced or where manual motor testing shows strength of grade 4 less	**5**
4.	**Positive Phalen's test** Flexion of the wrist reproduces her worsened symptoms of numbness in the median nerve territory	**5**
5.	**Loss of 2-point discrimination** Failure to discriminate 2 points held 5 mm or less apart from one another, in the median innervated digits	**4.5**
6.	**Positive Tinel sign** Light tapping over the median nerve at the level of the carpal tunnel causing radiating paraesthesias	**4**
	Total	**(26)**

Source: **https://pmc.ncbi.nlm.nih.gov/articles/PMC11936252/table/pone.0319158.t001/**. Accessed January 20, 2026

Evidence Review

Description

Carpal tunnel syndrome is a common condition which usually occurs more frequently in women than men and in those over 40 years of age. It is caused by compression of the median nerve, which runs the length of the arm and travels through the wrist. The median nerve is surrounded by bones and tendons on the palm side of the hand and the transverse carpal ligament covers the nerve across the top like a roof. The compression of the median nerve may lead to symptoms such as numbness, tingling, and pain in the hands and fingers. There may also be weakness when gripping objects. When conservative measures fail to relieve the symptoms, endoscopic or open surgery may be required for treatment of this condition.

Background

Carpal tunnel syndrome is a common condition which usually occurs more frequently in women than men and in those over 40 years of age. It is caused by compression of the median nerve, which runs the length of the arm and travels through the wrist. The median nerve is surrounded by bones and tendons on the palm side of the hand and the transverse carpal ligament covers the nerve across the top like a roof. The compression of the median nerve may lead to symptoms such as numbness, tingling, and pain in the hands and fingers, such as the thumb, index, middle fingers, and the thumb side of the ring finger. The little finger is not affected. There may also be weakness in the hand causing an individual to drop objects or have difficulty gripping objects. These symptoms may initially be mild and progressively worsen over time. For some individuals, the pain may occur more prominently at nighttime due to the tendency of some to bend their wrists while sleeping.

The etiology of carpal tunnel compression may be difficult to attribute to just one cause. There may be an anatomical change such as a small wrist or fracture, a disease such as osteoarthritis, rheumatoid arthritis, diabetes, pregnancy, obesity, or hypothyroidism that may cause swelling, irritation, or inflammation to the area. It is also believed that repetitive movements such as working a cash register, working on an assembly line, working with vibrating tools or swinging a hammer may lead to compression of the median nerve.

Treatment

The primary goal of any treatment for carpal tunnel syndrome is to relieve any pressure on the median nerve that may be producing the symptoms an individual is experiencing. Non-surgical treatment may include the use of NSAIDs, oral steroids, injection of corticosteroids, or wrist splinting. If these conservative measures fail to bring about any lasting relief, then surgical treatments such as an endoscopic or open carpal tunnel release may be warranted where the transverse carpal ligament is cut to relieve the pressure on the median nerve and to create more space in the tunnel. Electrodiagnostic testing such as a nerve conduction study should be performed prior to surgical intervention to confirm the clinical diagnosis and to define the extent of the median nerve injury. In the open procedure, a small incision is made in the palm of the hand or wrist where the surgeon has direct visual access to cut the transverse carpal ligament. In the endoscopic procedure, the surgeon, through a tiny incision at the wrist, inserts a small flexible tube with a camera attached to view the transverse carpal tunnel ligament through the camera, then another tiny incision is made for the tools used to cut the ligament. In certain

cases, the surgeon may use only one tiny incision for both the tube and the cutting tool, this is referred to as a single portal technique.

Two newer forms of less invasive treatment are being investigated: thread carpal tunnel release and ultrasound-guided percutaneous carpal tunnel release. Thread carpal tunnel release "transects the transverse carpal ligament by sawing the ligament with a piece of surgical thread looped percutaneously under the guidance of ultrasound."[13] It is proposed that this method spares injury to adjacent tissues as it uses only two puncture sites, one for entry and one for exit. As there is no incision, it can be performed in the office with local anesthesia. There is no scarring with this method and return to work is within a few days after the procedure. This procedure has primarily been performed on cadavers and continues to be modified to find the most suitable spinal needle and method for entry and exit. Hydrodissection is used throughout the procedure during visualization with ultrasound to separate the tissues associated with carpal tunnel syndrome. In the study conducted by Guo, et al (2017),[15] (n=159), there were 39 males and 77 females, and 43 participants had the procedure performed on both hands, but on different dates. Outcome measurements were determined by participant responses to the Boston Carpal Tunnel Syndrome Questionnaire (BCTQ). The outcomes were then compared to outcomes in the published medical literature (Trumble, et al)[2]. A modified TCTR approach was used with entry being at the palm and the exit at the wrist whereas the procedure had previously been performed with entry at the wrist and exit at the palm. The results demonstrated that the symptom severity mean score and the functional status score were better for TCTR at one day and one month, respectively than published scores of ECTR/OCTR at one year. The limitations of the study were small sample size and the cases that were followed-up to six months dropped to n=96 of the initial participants, also the study did not have a control comparator.

Ultrasound-guided percutaneous needle carpal tunnel release is similar to the thread carpal tunnel release in that only two small incisions are used under ultrasound guidance with hydrodissection; however, the tool used to release the transverse carpal ligament varies. Tools that have been used are a hook knife, a surgical thread, and angle blade or a needle[18]. In the controlled trial (the non-operated hand was considered the control) conducted by Burnham, et al, (2021)[20], a surgical cutting thread was inserted via a surgical spinal needle under ultrasound guidance and hydrodissection. Several outcome measures were collected such as symptoms and functional limitation severity, hand monofilament sensibility, grip and pinch strength, US-derived median nerve cross-sectional area at the carpal tunnel inlet and at the pronator quadratus, and nerve conduction studies of the median nerve across the carpal tunnel. The results demonstrated significant improvement in pain and dysfunction particularly in the first month post-surgery and a slight continued improvement for 6 months. However, there was also improvement in the non-operative hand as well just not as much as in the operative hand. There

was no significant change in hand sensibility or grip strength, but there was statistically significant improvement in pinch strength. There was reduced median nerve cross sectional area at the carpal tunnel inlet along with electrophysiologic improvements in median nerve function[20]. The limitations of the study included sample sizes that were very small (n=≤20) with limited six-month follow-up. The control was not independent as it was found that 13 of the 20 untreated "control hands" had symptomatic carpal tunnel syndrome, and one of the three assessors was not blinded to the treated hand. Additional well-designed studies are needed to determine the health outcome of these newer minimally invasive surgical treatment techniques compared to the standard treatment of endoscopic or open carpal tunnel release.

Summary of Evidence

For individuals diagnosed with carpal tunnel syndrome who receive carpal tunnel release surgery (endoscopic or open), the evidence includes numerous systematic reviews and meta-analyses of RCTs which showed that open and endoscopic carpal tunnel release are both about as effective in relieving symptoms and improving an individual's functional status. There may be a benefit in improvement of grip strength, fewer minor complications, and quicker return to work with endoscopic surgery versus open surgery[10,11,12,16] The evidence also suggests that injection of a corticosteroid may provide symptom relief and delay surgery better than wearing a night splint or using oral steroids; however, the symptom relief is usually short-term.[7,15,17,19,.21] The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

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.

The American Academy of Orthopedic Surgeons (AAOS)

In 2024, the AAOS published an evidence-based clinical practice guideline on the management of carpal tunnel syndrome that was endorsed by the American Association for Hand Surgery (AAHS)[26]. In the guideline the AAOS made the following recommendations:

- Strong evidence suggests corticosteroid injection does not provide long-term improvement of carpal tunnel syndrome
- Strong evidence suggests PRP Injection does not provide long-term benefits in non-operative treatment of carpal tunnel syndrome (leukocyte rich or leukocyte poor PRP)
- Strong evidence suggests that there is no difference in patient reported outcomes between a mini-open carpal tunnel release and an endoscopic carpal tunnel release
- Strong evidence suggests local anesthesia alone can be used for carpal tunnel release
- Evidence suggests therapeutic ultrasound does not provide long-term improvement of carpal tunnel syndrome
- Evidence suggests the following non-operative treatments do not improve long-term patient reported outcomes for carpal tunnel syndrome: oral corticosteroid, hyaluronic acid injection, hydro dissection, kinesiotaping, laser therapy, peloid therapy, perineural injection therapy, topical treatment, shockwave therapy, exercise, ozone injection, massage therapy, manual therapy, pulsed radiofrequency
- Evidence suggests no significant difference in patient reported outcomes between non operative treatment techniques for carpal tunnel syndrome

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Carpal tunnel release is a surgical procedure and, as such, is not subject to regulation by the US FDA.

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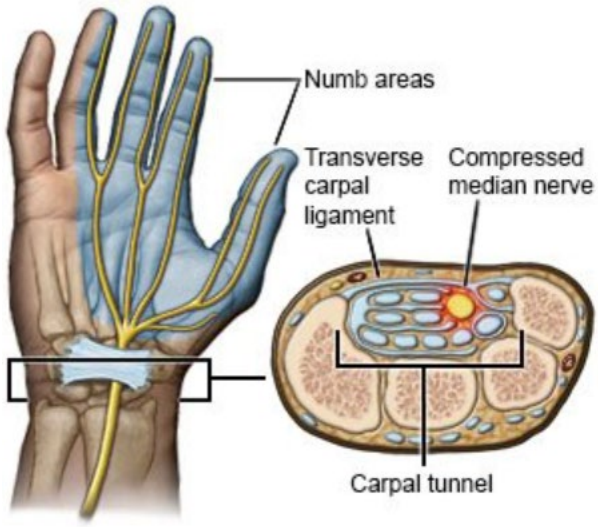
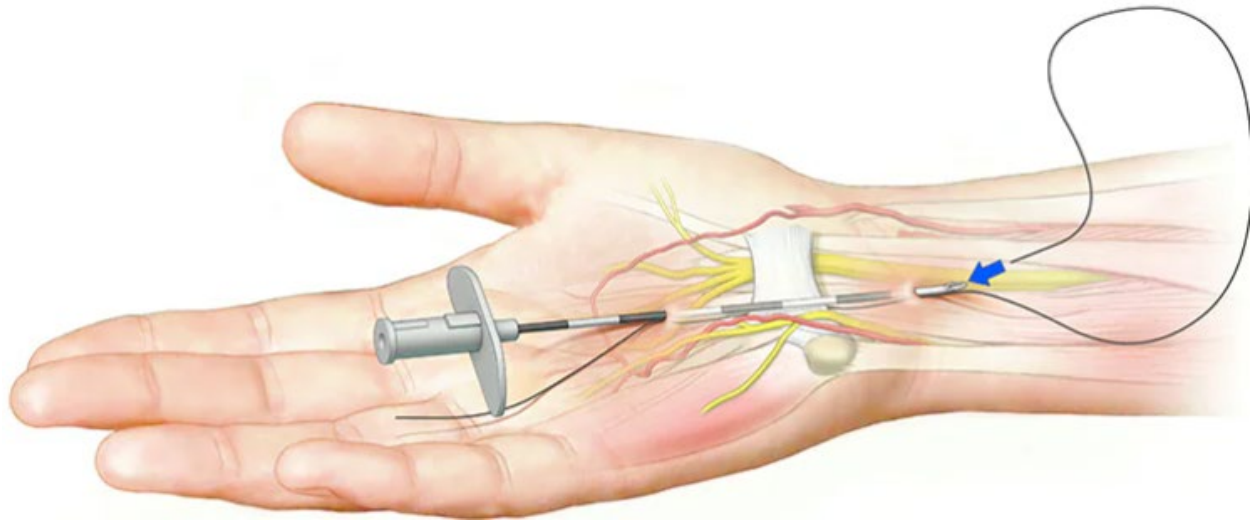
Appendix



Carpal Tunnel Syndrome

Source: **https://www.drugs.com/cg/carpal-tunnel-syndrome.html** Accessed November 19, 2025.

Percutaneous Carpal Tunnel Release



Source: **https://www.mayoclinic.org/medical-professionals/physical-medicine-rehabilitation/news/new-approaches-to-carpal-tunnel-release-and-treatment-of-tendinopathy/mac-20521546** Accessed November 19, 2025.

History

Date	Comments
02/01/25	New policy, approved January 14, 2025, effective for dates of service on or after May 6, 2025, following 90-day provider notification. Add to Surgery section. Carpal tunnel release is considered medically necessary for individuals with carpal tunnel syndrome who have failed conservative therapy when criteria are met. CPT codes 25999, 29848, 64721 and 64999.
12/01/25	Interim Review, approved November 11, 2025. Policy statements have changed: criteria language was modifed for greater ease of understanding. Provocative tests now included along with CTS-6 evaluation tool score for added simplicity in completing a medical necessity review. Policy intent unchanged.
01/01/26	Coding update. Added new CPT code 64728 effective January 1, 2026. Made style correction; replaced “is” with “may be” in the policy statement to adhere to guidelines for consistency.
03/01/26	Interim Review, approved February 10, 2026. Carpal tunnel release surgery medical necessity criteria simplified and changed to the following: Documentation supports a

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	clinical diagnosis of carpal tunnel syndrome in either of the following situations: Electrodiagnostic testing (e.g. nerve conduction study, electromyography) confirms carpal tunnel syndrome or the individual has a Carpal Tunnel Symptom Scale (CTS)-6 evaluation tool score of greater than 12. Added ultrasound-guided percutaneous intracarpal tunnel balloon dilation release to the list of surgical techniques for the treatment of carpal tunnel syndrome that are considered investigational. The following policy change is effective for dates of service on or after June 5, 2026, following 90-day provider notification. Site of Service Ambulatory Service Center (ASC) Select Diagnostic or Surgical Procedures criteria added.

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). ©2026 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.