SUBJECT: Technical Revisions Only to the National Coverage Determination (NCD) Manual

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to announce technical changes that were made to the National Coverage Determination (NCD) Manual, Publication 100-03, Chapter 1, Parts 1, 2, 3, and 4.

EFFECTIVE DATE: April 10, 2023
*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: April 10, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.
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<thead>
<tr>
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<td>R</td>
<td>1/20/20.5/Extracorporeal Immunoadsorption (ECI) Using Protein A Columns</td>
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<td>1/20/20.9/Artificial Hearts And Related Devices</td>
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<td>2/110/110.8.1/Stem Cell Transplantation</td>
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<td>2/110/110.19/Abarelix for the Treatment of Prostate Cancer (Effective March 15, 2005)</td>
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<td>2/160/160.9/Electroencephalographic (EEG) Monitoring During Open-Heart Surgery</td>
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<td>R</td>
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<td>4/220/220.6.12/FDG PET for Soft Tissue Sarcoma</td>
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<td>4/220/220.6.14/FDG PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers</td>
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<td>4/220/220.6.15/FDG PET for All Other Cancer Indications Not Previously Specified</td>
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<td>4/220/220.6.16/FDG PET for Infection and Inflammation (Effective March 19, 2008)</td>
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<td>4/220/220.7/Xenon Scan</td>
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<td>R</td>
<td>4/220/220.8/Nuclear Radiology Procedure</td>
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<td>4/230/230.11/Diagnostic Pap Smears</td>
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<td>R</td>
<td>4/240/240.2.2/Home Oxygen Use to Treat Cluster Headache (CH) (Effective January 4, 2011)</td>
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<td>R</td>
<td>4/240/240.6/Transverse (Catheter) Pulmonary Embolectomy</td>
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<td>4/280/280.13/Transcutaneous Electrical Nerve Stimulators (TENS)</td>
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</table>

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction
SUBJECT: Technical Revisions Only to the National Coverage Determination (NCD) Manual

EFFECTIVE DATE: April 10, 2023
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: April 10, 2023

I. GENERAL INFORMATION

A. Background: CMS periodically identifies and proposes to retire NCDs that no longer contain clinically pertinent and/or current information or no longer reflect current medical practice. In the absence of NCDs, coverage determinations are made by the Medicare Administrative Contractors (MACs) under section 1862(a)(1)(A) of the Social Security Act. For historical purposes, those actions are then reflected in updates to Publication (Pub) 100-03, the NCD Manual.

B. Policy: For purposes of clarity, consistency, and accuracy, we are making editorial/technical revisions to the NCD Manual, Chapter 1, Parts 1, 2, 3, and 4, related to historical NCD retirements. There is nothing included in this update that revises current policy and that has not already been conveyed to the public via previous CRs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
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<td>A/B MAC</td>
<td>DME MAC</td>
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<td>A</td>
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<tr>
<td>13105.1</td>
<td>Contractors shall be aware of the technical revisions to the NCD Manual as noted above. No policy is affected by these revisions.</td>
<td>X</td>
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III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
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<th>Responsibility</th>
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<tr>
<td>13105.2</td>
<td>CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on</td>
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<td>Number</td>
<td>Requirement</td>
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their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
</table>

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Lisa Davis, 410-786-4334 or lisa.davis@cms.hhs.gov, Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocatosimons@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0
Transmittals for Chapter 1, Part 1

20.5- Extracorporeal Immunoabsorption (ECI) Using Protein A Columns (RETIRED)
20.9- Artificial Hearts And Related Devices (RETIRED)
20.10- Cardiac Rehabilitation Programs (RETIRED)
20.25 - Cardiac Catheterization Performed in Other Than a Hospital Setting (RETIRED)
30.4- Electrosleep Therapy (RETIRED)
50.6 -Tinnitus Masking (RETIRED)
20.5 - Extracorporeal Immunoadsorption (ECI) Using Protein A Columns *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Extracorporeal Immunoadsorption (ECI) Using Protein A Columns. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under 1862(a)(1)(A) of the Social Security Act.

20.9 – Artificial Hearts and Related Devices) *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

*This section has been removed from the NCD Manual and incorporated into NCD 20.9.1 effective December 1, 2020.*

20.10 - Cardiac Rehabilitation Programs *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

This section of the NCD Manual was repealed February 22, 2010, as a result of section 144 of the Medicare Improvements for Patients and Providers Act. Instead, refer to Pub. 100-04, chapter 32, section 140.

20.25 - Cardiac Catheterization Performed in Other Than a Hospital Setting *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

*This section of the NCD Manual was repealed January 12, 2006.*

30.4 - Electrosleep Therapy *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Electrosleep Therapy. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under 1862(a)(1)(A) of the Social Security Act.

50.6 - Tinnitus Masking *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

*This section of the NCD Manual was retired December 18, 2014.*
Transmittals for Chapter 1, Part 2

100.1 – Intestinal Bypass Surgery (RETIRED)
100.2 - Implantation of Anti-Gastroesophageal Reflux Device (RETIRED)
100.3 - Injection Sclerotherapy for Esophageal Variceal Bleeding
100.4 – Gastric Balloon for Treatment of Obesity (RETIRED)
100.5 - Gastrophotography
100.6 - Laparoscopic Cholecystectomy
100.7 – Surgery for Diabetes (RETIRED)

110 - Hematology/Immunology/Oncology

110.1 - Hyperthermia for Treatment of Cancer
110.2 - Certain Drugs Distributed by the National Cancer Institute
110.3 - Anti-Inhibitor Coagulant Complex (AICC)
110.4 - Extracorporeal Photopheresis
110.5 - Granulocyte Transfusions
110.6 - Scalp Hypothermia During Chemotherapy to Prevent Hair Loss
110.7 - Blood Transfusions
110.8 - Blood Platelet Transfusions

110.8.1 - Stem Cell Transplantation (RETIRED)
110.9 - Antigens Prepared for Sublingual Administration
110.10 - Intravenous Iron Therapy
110.11 - Food Allergy Testing and Treatment
110.12 - Challenge Ingestion Food Testing
110.13 - Cytotoxic Food Tests
110.14 - Apheresis (Therapeutic Pheresis)
110.15 - Ultrafiltration, Hemoperfusion and Hemofiltration
110.16 - Nonselective (Random) Transfusions and Living Related Donor Specific Transfusions (DST) in Kidney Transplantation

110.17 - Anti-cancer Chemotherapy for Colorectal Cancer (Effective January 28, 2005)

110.18 - Aprepitant for Chemotherapy-Induced Emesis

110.19 – Abarelx for the Treatment of Prostate Cancer (Effective March 15, 2005) (RETIRED)

110.20 - Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors (Effective March 20, 2007)

110.21 - Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

110.22 – Autologous Cellular Immunotherapy Treatment (Effective June 30, 2011)

110.23 - Stem Cell Transplantation (Formerly 110.8.1) (Various Effective Dates)

110.24 - Chimeric Antigen Receptor (CAR) T-cell therapy

120 - Infectious Diseases

130 - Mental Health

130.1 - Inpatient Hospital Stays for the Treatment of Alcoholism

130.2 - Outpatient Hospital Services for Treatment of Alcoholism

130.3 - Chemical Aversion Therapy for Treatment of Alcoholism

130.4 - Electrical Aversion Therapy for Treatment of Alcoholism

130.5 - Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic

130.6 - Treatment of Drug Abuse (Chemical Dependency)

130.7 - Withdrawal Treatments for Narcotic Addictions

130.8 - Hemodialysis for Treatment of Schizophrenia

140 - Miscellaneous Surgical Procedures

140.1 - Abortion

140.2 - Breast Reconstruction Following Mastectomy

140.4 - Plastic Surgery to Correct “Moon Face"

140.5 - Laser Procedures

140.6 – Wrong Surgical or Other Invasive Procedure Performed on a Patient (Effective January 15, 2009)

140.7 – Surgical or Other Invasive Procedure Performed on the Wrong Body Part (Effective January 15, 2009)

140.8 – Surgical or Other Invasive Procedure Performed on the Wrong Patient (Effective January 15, 2009)

140.9 - Gender Reassignment Surgery for Gender Dysphoria

150 - Musculoskeletal System

150.1 - Manipulation

150.2 - Osteogenic Stimulator

150.3 - Bone (Mineral) Density Studies (Effective January 1, 2007)

150.5 - Diathermy Treatment

150.6 - Vitamin B12 Injections to Strengthen Tendons, Ligaments, etc., of the Foot

150.7 - Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents

150.8 - Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders

150.9 - Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (Effective June 11, 2004)

150.10 - Lumbar Artificial Disc Replacement (LADR) (Effective August 14, 2007)

150.11 – Thermal Intraradical Procedures (Effective September 29, 2008)

150.12 – Collagen Meniscus Implant (Effective May 25, 2010)
150.13 - Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) (Various Effective Dates)
150.20 – Reserved for Future Use
160 - Nervous System
   160.1 - Induced Lesions of Nerve Tracts
   160.2 - Treatment of Motor Function Disorders with Electric Nerve Stimulation
   160.4 - Stereotactic Cingulotomy as a Means of Psychosurgery *(RETIRED)*
   160.5 - Stereotaxic Depth Electrode Implantation
   160.6 - Carotid Sinus Nerve Stimulator *(RETIRED)*
   160.7 - Electrical Nerve Stimulators
   160.7.1 - Assessing Patients Suitability for Electrical Nerve Stimulation Therapy
   160.8 - Electroencephalographic Monitoring During Surgical Procedures Involving the Cerebral Vasculature
   160.9 – Electroencephalographic (EEG) Monitoring During Open-Heart Surgery *(RETIRED)*
   160.10 - Evoked Response Tests
   160.12 - Neuromuscular Electrical Stimulator (NMES)
   160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)
   160.14 - Invasive Intracranial Pressure Monitoring
   160.15 - Electrotherapy for Treatment of Facial Nerve Palsy (Bell’s Palsy)
   160.16 - Vertebral Axial Decompression (VAX-D)
   160.17 - L-Dopa
   160.18 - Vagus Nerve Stimulation (VNS)
   160.19 - Phrenic Nerve Stimulator
   160.20 - Transfer Factor for Treatment of Multiple Sclerosis
   160.21 - Telephone Transmission of EEGs
   160.22 - Ambulatory EEG Monitoring *(RETIRED)*
   160.23 - Sensory Nerve Conduction Threshold Tests (sNCTs)
   160.24 – Deep Brain Stimulation for Essential Tremor and Parkinson’s Disease
   160.25 - Multiple Electroconvulsive Therapy (MECT)
   160.26 - Cavernous Nerves Electrical Stimulation With Penile Plethysmography (Effective August 24, 2006)
   160.27 – Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
100.8 - Intestinal Bypass Surgery *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Please note section 100.8 has been removed from the NCD Manual and incorporated into NCD 100.1 effective September 24, 2013.

100.9 - Implantation of Anti-Gastroesophageal Reflux Device *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for FDG PET for Implantation of Gastrointestinal Reflux Devices. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under 1862(a)(1)(A) of the Social Security Act.

100.11 – Gastric Balloon for Treatment of Obesity *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Please note section 100.11 has been removed from the NCD Manual and incorporated into NCD 100.1 effective September 24, 2013.

100.14 – Surgery for Diabetes *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Please note section 100.14 has been removed from the NCD Manual and incorporated into NCD 100.1 effective September 24, 2013.

110.8.1 – Stem Cell Transplantation *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective January 27, 2016 NCD 110.8.1 is retired and incorporated into NCD 110.23.

110.19 - Abarelix for the Treatment of Prostate Cancer *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Abarelix for the Treatment of Prostate Cancer. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under 1862(a)(1)(A) of the Social Security Act.

160.4 – Stereotactic Cingulotomy as a Means of Psychosurgery *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective December 18, 2014, NCD 160.4 is retired.

160.6 – Carotid Sinus Nerve Stimulator *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective December 18, 2014, NCD 160.6 is retired.

160.9 – Electroencephalographic (EEG) Monitoring During Open-Heart Surgery *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*
Effective December 18, 2014, NCD 160.9 is retired.

160.22 – Ambulatory EEG Monitoring *(RETIRED)*
 *(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation: 04-10-23)*

*Effective January 1, 2023, NCD 160.22 is retired.*
Medicare National Coverage Determinations
Manual
Chapter 1, Part 3 (Sections 170 – 190.34)
Coverage Determinations

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(Rev. 11892; Issued:03-09-23)

Transmittals for Chapter 1, Part 3

170 - Nonphysician Practitioner Services (PT/OT/SLP/Audiologists/CRNA)
   170.1 – Institutional and Home Care Patient Education Programs
   170.2 – Melodic Intonation Therapy
   170.3 – Speech-Language Pathology Services for the Treatment of Dysphagia

180 – Nutrition
   180.1 – Medical Nutrition Therapy (MNT)
   180.2 – Enteral and Parenteral Nutritional Therapy (RETIRED)

190 – Pathology and Laboratory
   190.1 – Histocompatibility Testing
   190.2 – Diagnostic Pap Smears
   190.3 – Cytogenetic Studies
   190.4 – Electron Microscope (RETIRED)
180.2 - Enteral and Parenteral Nutritional Therapy (RETIRED)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Effective January 1, 2022, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Enteral and Parenteral Nutritional Therapy. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under 1862(a)(1)(A) of the Social Security Act.

190.4 – Electron Microscope (RETIRED)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Effective December 18, 2014, NCD 190.4 is retired.
Medicare National Coverage Determinations Manual
Chapter 1, Part 4 (Sections 200 – 310.1)
Coverage Determinations

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(Rev. 11892; Issued: 03-09-23)

Transmittals for Chapter 1, Part 4

200 - Pharmacology
  200.1 - Nesiritide for Treatment of Heart Failure Patients (Effective March 2, 2006)
  200.2 - Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases - (Effective September 10, 2007)

210 - Prevention
  210.1 - Prostate Cancer Screening Tests
  210.2 - Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
    210.2.1 Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing (Effective July 9, 2015)
  210.3 – Colorectal Cancer Screening Tests
  210.4 – Smoking and Tobacco-Use Cessation Counseling (Effective March 22, 2005) (RETIRED)
    210.4.1 – Counseling to Prevent Tobacco Use (Effective August 25, 2010)
  210.5 - Diabetes Screening Tests (Effective January 1, 2005)
  210.6 - Screening for Hepatitis B Virus (HBV) Infection
  210.7 – Screening for Human Immunodeficiency Virus (HIV)
  210.8 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (Effective October 14, 2011)
  210.9 – Screening for Depression in Adults (Effective October 14, 2011)
  210.10 - Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs
  210.11 - Intensive Behavioral Therapy for Cardiovascular Disease
  210.12 – Intensive Behavioral Therapy for Obesity
  210.13 - Screening for Hepatitis C Virus (HCV) in Adults
  210.14 – Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

220 - Radiology
220.1 - Computed Tomography (CT)
220.2 - Magnetic Resonance Imaging (MRI) (Various Effective Dates Below)
   220.2.1 - Magnetic Resonance Spectroscopy (RETIRED)
220.3 - Magnetic Resonance Angiography (RETIRED)
220.4 - Mammograms
220.5 - Ultrasound Diagnostic Procedures (Effective May 22, 2007)
220.6 – Positron Emission Tomography (PET) Scans (Effective April 6, 2009) (RETIRED)
   220.6.1 – PET for Perfusion of the Heart (Various Effective Dates)
   220.6.2 – FDG PET for Lung Cancer (RETIRED)
   220.6.3 – FDG PET for Esophageal Cancer (RETIRED)
   220.6.4 – FDG PET for Colorectal Cancer (RETIRED)
   220.6.5 – FDG PET for Lymphoma (RETIRED)
   220.6.6 – FDG PET for Melanoma (RETIRED)
   220.6.7 – FDG PET for Head and Neck Cancers (RETIRED)
   220.6.8 – FDG PET for Myocardial Viability
   220.6.9 – FDG PET for Refractory Seizures
   220.6.10 – FDG PET for Breast Cancer (RETIRED)
   220.6.11 – FDG PET for Thyroid Cancer (RETIRED)
   220.6.12 – FDG PET for Soft Tissue Sarcoma (RETIRED)
   220.6.13 – FDG Positron Emission Tomography (PET) for Dementia and Neurodegenerative Diseases (Effective September 15, 2004)
   220.6.14 – FDG PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers (RETIRED)
   220.6.15 – FDG PET for All Other Cancer Indications Not Previously Specified (RETIRED)
   220.6.16 - FDG PET for Infection and Inflammation (Effective March 19, 2008) (RETIRED)
   220.6.17 - Positron Emission Tomography (PET) (FDG) for Oncologic Conditions - (Effective June 11, 2013)
   220.6.19 - Positron Emission Tomography NaF-18 (NaF-18 PET) to Identify Bone Metastasis of Cancer (Effective February 26, 2010)
   220.6.20 -Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease
220.7 - Xenon Scan (RETIRED)
220.8 - Nuclear Radiology Procedure (RETIRED)
220.9 - Digital Subtraction Angiography (DSA)
220.10 - Portable Hand-Held X-Ray Instrument
220.11 - Thermography
220.12 - Single Photon Emission Computed Tomograph (SPECT)
220.13 - Percutaneous Image-Guided Breast Biopsy
230 - Renal and Genitourinary System - ESRD Services

230.1 - Treatment of Kidney Stones
230.2 - Uroflowmetric Evaluations
230.3 - Sterilization
230.4 - Diagnosis and Treatment of Impotence
230.5 - Gravlee Jet Washer
230.6 - Vabra Aspirator
230.7 - Water Purification and Softening Systems Used in Conjunction With Home Dialysis
230.8 - Non-Implantable Pelvic Floor Electrical Stimulator
230.9 - Cryosurgery of Prostate
230.10 - Incontinence Control Devices
230.11 - Diagnostic Pap Smears (RETIRED)
230.12 - Dimethyl Sulfoxide (DMSO)
230.13 - Peridex CAPD Filter Set
230.14 - Ultrafiltration Monitor
230.15 - Electrical Continence Aid
230.16 - Bladder Stimulators (Pacemakers)
230.17 - Urinary Drainage Bags
230.18 - Sacral Nerve Stimulation for Urinary Incontinence
230.19 - Levocarnitine for Use in the Treatment of Carnitine Deficiency in ESRD Patients

240 - Respiratory System

240.1 - Lung Volume Reduction Surgery (Reduction Pneumoplasty) (Various Effective Dates Below)
240.2 - Home Use of Oxygen
  240.2.1 - Home Use of Oxygen in Approved Clinical Trials (Effective March 20, 2006)
  240.2.2 – Home Oxygen Use to Treat Cluster Headache (CH) (Effective January 4, 2011) (RETIRED)
240.3 - Heat Treatment, Including the Use of Diathermy and Ultra-Sound for Pulmonary Conditions
240.4 - Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (Effective March 13, 2008)
  240.4.1 - Sleep Testing for Obstructive Sleep Apnea (OSA) (Effective March 3, 2009)
240.5 - Intrapulmonary Percussive Ventilator (IPV)
240.6 - Transvenous (Catheter) Pulmonary Embolectomy (RETIRED)
240.7 - Postural Drainage Procedures and Pulmonary Exercises
240.8 - Pulmonary Rehabilitation Services
250 - Skin
   250.1 - Treatment of Psoriasis
   250.2 - Hemorheograph
   250.3 - Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases
   250.4 - Treatment of Actinic Keratosis
   250.5 - Dermal Injections for the Treatment of Facia Lipodystrophy Syndrome (LDS)

260 - Transplantation - Solid Organ Transplants
   260.1 - Adult Liver Transplantation
   260.2 - Pediatric Liver Transplantation
   260.3 - Pancreas Transplants (Effective April 26, 2006)
      260.3.1 – Islet Cell Transplantation in the Context of a Clinical Trial
   260.4 - Reserved
   260.5 - Intestinal and Multi-Visceral Transplantation (Effective May 11, 2006)
   260.6 - Dental Examination Prior to Kidney Transplantation
   260.7 - Lymphocyte Immune Globulin, Anti-Thymocyte Globulin (Equine)
   260.8 - Reserved
   260.9 - Heart Transplants
   260.10 - Heartsbreath Test for Heart Transplant Rejection (Effective December 8, 2008)

270 - Wound Treatment
   270.1 - Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds – (Effective July 1, 2004)
   270.2 - Noncontact Normothermic Wound Therapy (NNWT)
   270.3 - Blood-Derived Products for Chronic Non-Healing Wounds – (Various Effective Dates Below)
   270.4 - Treatment of Decubitus Ulcers
   270.5 - Porcine Skin and Gradient Pressure Dressings
   270.6 - Infrared Therapy Devices (Effective October 24, 2006)

280 - Medical and Surgical Supplies
   280.1 - Durable Medical Equipment Reference List (Effective May 5, 2005)
   280.2 - White Cane for Use by a Blind Person
   280.3 - Mobility Assistive Equipment (MAE) (Effective May 5, 2005)
   280.4 - Seat Lift
   280.6 - Pneumatic Compression Devices
   280.7 - Hospital Beds
   280.8 - Air-Fluidized Bed
   280.10 - Prosthetic Shoe
280.11 - Corset Used as Hernia Support
280.12 - Sykes Hernia Control
280.13 - Transcutaneous Electrical Nerve Stimulators (TENS) *(RETIRED)*
280.14 – Infusion Pumps
280.15 - INDEPENDENCE iBOT 4000 Mobility System (Effective July 27, 2006)

290 - Nursing Services
290.1 - Home Health Visits to a Blind Diabetic
290.2 - Home Health Nurses’ Visits to Patients Requiring Heparin Injections

300 - Diagnostic Tests Not Otherwise Classified
300.1 - Obsolete or Unreliable Diagnostic Tests

310 - Clinical Trials
310.1 - Routine Costs in Clinical Trials (Effective July 9, 2007)
210.4- Smoking and Tobacco-Use Cessation Counseling *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective September 30, 2015 this section is deleted and the remaining NCD entitled Counseling to Prevent Tobacco Use (210.4.1) remains effective.

220.2.1- Magnetic Resonance Spectroscopy *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Magnetic Resonance Spectroscopy. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act.

220.3- Magnetic Resonance Angiography *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Please note section 220.3 has been removed from the NCD Manual and merged with section 220.2 effective June 3, 2010.

220.6- Positron Emission Tomography (PET) Scans *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective January 1, 2022, the Centers for Medicare & Medicaid Services removed the umbrella national coverage determination (NCD) for Positron Emission Tomography (PET) Scans. In the absence of an NCD, coverage determinations for all oncologic and non-oncologic uses of PET that are not included in another NCD under section 220.6 will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act. All PET indications currently covered or non-covered under NCDs under section 220.6 remain unchanged and MACs shall not alter coverage for indications covered under NCDs.

220.6.2- FDG PET for Lung Cancer *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Please note section 220.6.2 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.3- FDG PET for Esophageal Cancer *(RETIRED)*
*(Rev.11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Please note section 220.6.3 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.4- FDG PET for Colorectal Cancer *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Please note section 220.6.4 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.
220.6.5- FDG PET for Lymphoma (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.5 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.6- FDG PET for Melanoma (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.6 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.7- FDG PET for Head and Neck Cancers (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.7 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.10- FDG PET for Breast Cancer (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.10 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.11- FDG PET for Thyroid Cancer (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.11 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.12- FDG PET for Soft Tissue Sarcoma (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.12 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.14- FDG PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers (**RETIRED**)
(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.14 has been removed from the NCD Manual and replaced with section 220.6.17 effective April 3, 2009.

220.6.15- FDG PET for All Other Cancer Indications Not Previously Specified (**RETIRED**)
(Rev.11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)

Please note section 220.6.15 has been removed from the NCD Manual and replaced with section
220.6.17 effective April 3, 2009.

220.6.16- FDG PET for Infection and Inflammation *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective January 1, 2021, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for FDG PET for Inflammation and Infection. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act.

220.7- Xenon Scan *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective December 18, 2014, NCD 220.7 is retired.

220.8- Nuclear Radiology Procedure *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective December 18, 2014, NCD 220.8 is retired.

230.11- Diagnostic Pap Smears *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

The guide in §190.2 applies.

240.2.2- Home Oxygen Use to Treat Cluster Headache (CH) *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective September 27, 2021, the Centers for Medicare & Medicaid Services removed the national coverage determination (NCD) for home oxygen use to treat cluster headaches. In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act, as allowed and described in Chapter 1, Section 240.2 (Home Use of Oxygen), Subsection D, of Publication 100-03 of the NCD Manual.

240.6- Transverse (Catheter) Pulmonary Embolectomy *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Effective October 28, 2021, the Centers for Medicare & Medicaid Services removed the national coverage determination (NCD) for Transvenous (Catheter) Pulmonary Embolectomy (TPE). In the absence of an NCD, coverage determinations will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act.

280.13- Transcutaneous Electrical Nerve Stimulators (TENS) *(RETIRED)*
*(Rev. 11892; Issued: 03-09-23; Effective: 04-10-23; Implementation:04-10-23)*

Please note section 280.13 has been removed from the NCD Manual and incorporated into NCD 160.27 effective June 8, 2012.