

2025 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List Effective 1/1/2025 (Updated February 2025)

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding Systemcodes that, based on our medical policy, are:

- Subject to a medical necessity review,
- Candidates for a Recommended Clinical Review,
- Not a benefit for our members,
- Considered experimental, investigational and unproven (EIU), or
- Not on our prior authorization list (with some exceptions based on members' benefit plans)

Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025.

**Utilization Management Process** 

This file is a searchable PDF.
Press "CTRL" and "F" keys at the
same time to bring up the search
box. Enter a procedure code or
description of the service.

Procedure Code Group Description
Procedures/services reviewed against Medical Policy Criteria. Submit for
Recommended Clinical Review (Predetermination) to avoid post-service review.
Highlighted procedure/service in this code group may require Prior Authorization
per contract agreement.
Procedures/services not covered by the Plan. Not subject to pre-service review.
Procedures/services not reimbursed by the Plan. Not subject to pre-service
review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).
Procedures/services not specifically defined or classified, may be subject to contract/clinical review.

Note: Some codes will appear twice if Ending Date and Effective Date are within the same quarter period.

Procedure Code	Code Description		Code Group & Description	Effective Date   Endin	g Date
	Code Describtion				

640	Anesthesia For Manipulation Of The Spine Or For Closed Procedures On The Cervical, Thoracic Or Lumbar Spine	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2005	12/31/2999
	Gorrious, Friordolo of Editibal Opinio	Clinical Review to avoid post-service review.		
797	Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including	MP Criteria: Procedure/service reviewed against	11/15/2008	12/31/2999
01	Laparoscopy; Gastric Restrictive Procedure For Morbid Obesity	Medical Policy Criteria. Submit for Recommended	11/10/2000	12/01/2000
	Laparocoopy, Gastrio Restrictive 1 research 1 of World Obesity	Clinical Review to avoid post-service review.		
11055	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg, Corn Or Callus); Single	MP Criteria: Procedure/service reviewed against	9/1/2007	12/31/2999
11000	Lesion	Medical Policy Criteria. Submit for Recommended	0/1/2007	12/01/2000
	Ecolori	Clinical Review to avoid post-service review.		
11056	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg, Corn Or Callus); 2 To 4	MP Criteria: Procedure/service reviewed against	9/1/2007	12/31/2999
. 1000	Lesions	Medical Policy Criteria. Submit for Recommended	0/1/2007	12/01/2000
	Ecolorio	Clinical Review to avoid post-service review.		
11057	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg, Corn Or Callus); More	MP Criteria: Procedure/service reviewed against	9/1/2007	12/31/2999
. 1001	Than 4 Lesions	Medical Policy Criteria. Submit for Recommended	0/ 1/2007	12/01/2000
	Than I Essions	Clinical Review to avoid post-service review.		
11200	Removal Of Skin Tags, Multiple Fibrocutaneous Tags, Any Area; Up To And	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
50	Including 15 Lesions	Medical Policy Criteria. Submit for Recommended	5,2 1,20 12	.2,01,2000
	Initiating to Essions	Clinical Review to avoid post-service review.		
11201	Removal Of Skin Tags, Multiple Fibrocutaneous Tags, Any Area; Each Additional	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
. 1201	10 Lesions, Or Part Thereof (List Separately In Addition To Code For Primary	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	Procedure)	Clinical Review to avoid post-service review.		
1719	Trimming Of Nondystrophic Nails, Any Number	MP Criteria: Procedure/service reviewed against	9/1/2007	12/31/2999
11710	Trimming of Norlayou opino Nailo, 7 try Nambor	Medical Policy Criteria. Submit for Recommended	0/1/2007	12/01/2000
		Clinical Review to avoid post-service review.		
11920	Tattooing, Intradermal Introduction Of Insoluble Opaque Pigments To Correct	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
11020	Color Defects Of Skin, Including Micropigmentation; 6.0 Sq Cm Or Less	Medical Policy Criteria. Submit for Recommended	172000	12/01/2000
	Color Bolodia Of Skill, illordallig Wilotopigilloritation, 0.0 oq Sill Of 2000	Clinical Review to avoid post-service review.		
11921	Tattooing, Intradermal Introduction Of Insoluble Opaque Pigments To Correct	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
. 1021	Color Defects Of Skin, Including Micropigmentation; 6.1 To 20.0 Sq Cm	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	Color Bolodic of Chin, moraling microphymorhalion, c. 1 10 20.0 64 611	Clinical Review to avoid post-service review.		
11922	Tattooing, Intradermal Introduction Of Insoluble Opaque Pigments To Correct	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Color Defects Of Skin, Including Micropigmentation; Each Additional 20.0 Sq Cm,	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
11950	Subcutaneous Injection Of Filling Material (Eg, Collagen); 1 Cc Or Less	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
. 1000	Substitutional injection of thining material (Eg, Solidgen), 1 00 01 2000	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
11951	Subcutaneous Injection Of Filling Material (Eg, Collagen); 1.1 To 5.0 Cc	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
. 1001	Substitutional injection of thining material (Eg, Solidgen), 1.1 10 0.0 00	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
11952	Subcutaneous Injection Of Filling Material (Eg, Collagen); 5.1 To 10.0 Cc	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
11002	Substitutional injection of thining material (29, conagon), c. 1 10 10.0 cc	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
11954	Subcutaneous Injection Of Filling Material (Eg, Collagen); Over 10.0 Cc	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Table and the second of thining material (Eg, Collagori), Over 10.0 Oc	Medical Policy Criteria. Submit for Recommended	., ., 2000	12,01,2000
		Clinical Review to avoid post-service review.		
11960	Insertion Of Tissue Expander(S) For Other Than Breast, Including Subsequent	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
1 1000	Expansion	Medical Policy Criteria. Submit for Recommended	7/1/2000	12/01/2000
	EAPAI ISIOTI	Clinical Review to avoid post-service review.		
		Cililical Neview to avoid post-service review.		

1980	Subcutaneous Hormone Pellet Implantation (Implantation Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2005	12/31/2999
	Total Control Control Control Control	Clinical Review to avoid post-service review.		
1981	Insertion, Drug-Delivery Implant (le, Bioresorbable, Biodegradable, Non-	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Biodegradable)	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
	Biodogiadabio)	Clinical Review to avoid post-service review.		
982	Removal, Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
002	Tromotal, from Bloadyladasio Brag Bolivery Implant	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
		Clinical Review to avoid post-service review.		
983	Removal With Reinsertion, Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
303	Themoval With Hemsertion, Non-blodegradable brug belivery implant	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
		Clinical Review to avoid post-service review.		
271	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
211	Application of Skin Substitute Graft to Hunk, Arms, Legs, Total Would Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	· ·	4/1/2023	12/31/2999
	Area up 10 100 Sq Citi, Filst 25 Sq Citi Of Less Woulld Surface Area	Medical Policy Criteria. Submit for Recommended		
070	And live the Of Ohio Only that A One for Target Annual Law Tatal Ways of One	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
272	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part	Medical Policy Criteria. Submit for Recommended		
	Thereof (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
273	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface	Medical Policy Criteria. Submit for Recommended		
	Area, Or 1% Of Body Area Of Infants And Children	Clinical Review to avoid post-service review.		
274	Application Of Skin Substitute Graft To Trunk, Arms, Legs, Total Wound Surface	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound	Medical Policy Criteria. Submit for Recommended		
	Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants	Clinical Review to avoid post-service review.		
	And Children, Or Part Thereof (List Separately In Addition To Code For Primary	·		
	Procedure)			
275	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area	Medical Policy Criteria. Submit for Recommended		
	Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	Clinical Review to avoid post-service review.		
276	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area	Medical Policy Criteria. Submit for Recommended		
	Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area, Or Part	Clinical Review to avoid post-service review.		
	Thereof (List Separately In Addition To Code For Primary Procedure)			
277	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area	Medical Policy Criteria. Submit for Recommended	., ., _ 0 _ 0	12/01/2000
	Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area, Or	Clinical Review to avoid post-service review.		
	1% Of Body Area Of Infants And Children	Chillical Review to avoid post service review.		
278	Application Of Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
210	Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area	Medical Policy Criteria. Submit for Recommended	4/1/2020	12/01/2000
	Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound	Clinical Review to avoid post-service review.		
	Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of Infants	Cliffical Review to avoid post-service review.		
	And Children, Or Part Thereof (List Separately In Addition To Code For Primary			
	Procedure)	MD Cuitouia Dua and una /a amilia a marijarra di anti-	44/45/2040	40/04/0000
758	Free Fascial Flap With Microvascular Anastomosis	MP Criteria: Procedure/service reviewed against	11/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
771	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	Breasts, Scalp, Arms, And/Or Legs; 50 Cc Or Less Injectate	Medical Policy Criteria. Submit for Recommended		
	1	Clinical Review to avoid post-service review.		1

15772	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	Breasts, Scalp, Arms, And/Or Legs; Each Additional 50 Cc Injectate, Or Part	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
	Thereof (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
15775	Punch Graft For Hair Transplant; 1 To 15 Punch Grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15776	Punch Graft For Hair Transplant; More Than 15 Punch Grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15780	Dermabrasion; Total Face (Eg, For Acne Scarring, Fine Wrinkling, Rhytids,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	General Keratosis)	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
15781	Dermabrasion; Segmental, Face	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15782	Dermabrasion; Regional, Other Than Face	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
1		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15783	Dermabrasion; Superficial, Any Site (Eg, Tattoo Removal)	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15786	Abrasion; Single Lesion (Eg, Keratosis, Scar)	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15787	Abrasion; Each Additional 4 Lesions Or Less (List Separately In Addition To Code	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	For Primary Procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15788	Chemical Peel, Facial; Epidermal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15789	Chemical Peel, Facial; Dermal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15792	Chemical Peel, Nonfacial; Epidermal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15793	Chemical Peel, Nonfacial; Dermal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15819	Cervicoplasty	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
15820	Blepharoplasty, Lower Eyelid;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
15821	Blepharoplasty, Lower Eyelid; With Extensive Herniated Fat Pad	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	<u> </u>	
15822	Blepharoplasty, Upper Eyelid;	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
•		Clinical Review to avoid post-service review.		

15823	Blepharoplasty, Upper Eyelid; With Excessive Skin Weighting Down Lid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
		Clinical Review to avoid post-service review.		
15825	Rhytidectomy; Neck With Platysmal Tightening (Platysmal Flap, P-Flap)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5828	Rhytidectomy; Cheek, Chin, And Neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5829	Rhytidectomy; Superficial Musculoaponeurotic System (Smas) Flap	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15830	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy);	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Abdomen, Infraumbilical Panniculectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15832	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Thigh	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5833	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Leg	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
		Clinical Review to avoid post-service review.		
5834	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Hip	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
		Clinical Review to avoid post-service review.		
15835	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Buttock	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10000	Excision, Excessive ordinaria oubcutaneous hissae (motudes Espectomy), Buttock	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/01/2000
		Clinical Review to avoid post-service review.		
5836	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Arm	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
13030	Excision, Excessive on And Subcutaneous Tissue (includes Electionly), Ann	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
15837	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
3037	Forearm Or Hand	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/3/1/2999
	l dealii Oi Haliu	•		
5838	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy);	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
3030	Submental Fat Pad	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
	Submental Fat Fat	Clinical Review to avoid post-service review.		
5839	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Other	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
2039	Area		9/24/2012	12/31/2999
	Area	Medical Policy Criteria. Submit for Recommended		
5847	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy),	Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
5847		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Abdomen (Eg, Abdominoplasty) (Includes Umbilical Transposition And Fascial	Medical Policy Criteria. Submit for Recommended		
5070	Plication) (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.	0/04/0040	40/04/0000
5876	Suction Assisted Lipectomy; Head And Neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5877	Suction Assisted Lipectomy; Trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	1	Clinical Review to avoid post-service review.		

15878	Suction Assisted Lipectomy; Upper Extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
5879	Suction Assisted Lipectomy; Lower Extremity	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7106	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique);	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Less Than 10 Sq Cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7107	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique);	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	10.0 To 50.0 Sq Cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7108	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg, Laser Technique);	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Over 50.0 Sq Cm	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
	0.01 0010 04 0	Clinical Review to avoid post-service review.		
7340	Cryotherapy (Co2 Slush, Liquid N2) For Acne	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
1010	orysmorapy (302 orasin, Elquid 142) 1 St 7 tollo	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
7360	Chemical Exfoliation For Acne (Eg, Acne Paste, Acid)	MP Criteria: Procedure/service reviewed against	3/1/2007	12/31/2999
7300	Chemical Exicilation For Achie (Eg. Achie Faste, Acid)	Medical Policy Criteria. Submit for Recommended	3/1/2007	12/31/2999
		Clinical Review to avoid post-service review.		
7380	Electrolysis Epilation, Each 30 Minutes	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
7300	Liectiolysis Epilation, Each 30 Minutes	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
9105	Ablation, Cryosurgical, Of Fibroadenoma, Including Ultrasound Guidance, Each	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
19103	Fibroadenoma	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
	i ibroaderiorita	Clinical Review to avoid post-service review.		
9300	Mastectomy For Gynecomastia	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
9300	Mastectorily For Cyriecomastia	Medical Policy Criteria. Submit for Recommended	3/1/2020	12/31/2999
		Clinical Review to avoid post-service review.		
9303	Mastectomy, Simple, Complete	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
9303	Mastectomy, Simple, Complete	Medical Policy Criteria. Submit for Recommended	1/1/2007	12/31/2999
		Clinical Review to avoid post-service review.		
9325	Breast Augmentation With Implant	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
9323	breast Augmentation with implant	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
		Clinical Review to avoid post-service review.		
9328	Removal Of Intact Breast Implant	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
9320	The moval of intact breast implant	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
		•		
9330	Removal Of Ruptured Breast Implant, Including Implant Contents (Eg, Saline,	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
<b>3</b> 330	Silicone Gel)	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/3/1/2999
	Silicone Ger)			
9340	Insertion Of Breast Implant On Same Day Of Mastectomy (le, Immediate)	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
9340	insertion of breast implant on Same Day of Mastectomy (le, immediate)		4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0040	In continue On Bonda consent Of Broad Involved On Occasion B	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
9342	Insertion Or Replacement Of Breast Implant On Separate Day From Mastectomy	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

19350	Nipple/Areola Reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	6/1/2017	12/31/2999
		Clinical Review to avoid post-service review.		
19355	Correction Of Inverted Nipples	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19357	Tissue Expander Placement In Breast Reconstruction, Including Subsequent	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
	Expansion(S)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19370	Revision Of Peri-Implant Capsule, Breast, Including Capsulotomy,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Capsulorrhaphy, And/Or Partial Capsulectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19371	Peri-Implant Capsulectomy, Breast, Complete, Including Removal Of All	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Intracapsular Contents	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19499	Unlisted Procedure, Breast	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
	J	Medical Policy Criteria. Submit for Recommended		12/01/2000
		Clinical Review to avoid post-service review.		
20527	Injection, Enzyme (Eg, Collagenase), Palmar Fascial Cord (Ie, Dupuytren'S	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
10021	Contracture)	Medical Policy Criteria. Submit for Recommended	17 172012	12/01/2000
	Contracture)	Clinical Review to avoid post-service review.		
20560	Needle Insertion(S) Without Injection(S); 1 Or 2 Muscle(S)		12/1/2020	12/31/2999
20300	Needle insertion(3) without injection(3), 1 Or 2 ividscle(3)	Not subject to pre-service review. Check EIU	12/1/2020	12/31/2999
		policy, which is one of our Clinical Payment and		
20504	N. H. J. C. (0) MCH. (1.1. C. (0) 0.0 M. M. J.	Coding Policy (CPCP).	40/4/0000	10/04/0000
20561	Needle Insertion(S) Without Injection(S); 3 Or More Muscles	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
20979	Low Intensity Ultrasound Stimulation To Aid Bone Healing, Noninvasive	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	(Nonoperative)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
20982	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg,	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
	Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension,	Medical Policy Criteria. Submit for Recommended		
	Percutaneous, Including Imaging Guidance When Performed; Radiofrequency	Clinical Review to avoid post-service review.		
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg,	MP Criteria: Procedure/service reviewed against	6/1/2023	12/31/2999
	Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension,	Medical Policy Criteria. Submit for Recommended		
	Percutaneous, Including Imaging Guidance When Performed; Cryoablation	Clinical Review to avoid post-service review.		
20985	Computer-Assisted Surgical Navigational Procedure For Musculoskeletal	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	Procedures, Image-Less (List Separately In Addition To Code For Primary	Not subject to pre-service review. Check EIU		
	Procedure)	policy, which is one of our Clinical Payment and		
	1.1000000	Coding Policy (CPCP).		
21073	Manipulation Of Temporomandibular Joint(S) (Tmj), Therapeutic, Requiring An	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
•	Anesthesia Service (le, General Or Monitored Anesthesia Care)	Medical Policy Criteria. Submit for Recommended		.2.0.,2000
	Allocationa control (10, contoral of Montariod Allocationa odio)	Clinical Review to avoid post-service review.		
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	MP Criteria: Procedure/service reviewed against	11/1/2007	12/31/2999
1000	Impression And Ediston i Teparation, Falatal Lilt Flustriesis	Medical Policy Criteria. Submit for Recommended	11/1/2007	12/3/1/233
		Clinical Review to avoid post-service review.		
	1	Cimical Review to avoid post-service review.		

21120	Genioplasty; Augmentation (Autograft, Allograft, Prosthetic Material)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
21121	Genioplasty; Sliding Osteotomy, Single Piece	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21122	Genioplasty; Sliding Osteotomies, 2 Or More Osteotomies (Eg, Wedge Excision	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Or Bone Wedge Reversal For Asymmetrical Chin)	Medical Policy Criteria. Submit for Recommended		
	, , , , ,	Clinical Review to avoid post-service review.		
21123	Genioplasty; Sliding, Augmentation With Interpositional Bone Grafts (Includes	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Obtaining Autografts)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21244	Reconstruction Of Mandible, Extraoral, With Transosteal Bone Plate (Eg,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Mandibular Staple Bone Plate)	Medical Policy Criteria. Submit for Recommended		1.2,0 %,200
	manaisaisi otapio 20118 i tato,	Clinical Review to avoid post-service review.		
21245	Reconstruction Of Mandible Or Maxilla, Subperiosteal Implant; Partial	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
-1210	Treestrict action of manages of maxima, caspendedar implant, randar	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
21246	Reconstruction Of Mandible Or Maxilla, Subperiosteal Implant; Complete	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L12-10	1 1000 lot dottol Of Mariable Of Maxilla, Subperiorical Implant, Somplete	Medical Policy Criteria. Submit for Recommended	4/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
21247	Reconstruction Of Mandibular Condyle With Bone And Cartilage Autografts	MP Criteria: Procedure/service reviewed against	5/15/2009	12/31/2999
21271	(Includes Obtaining Grafts) (Eg, For Hemifacial Microsomia)	Medical Policy Criteria. Submit for Recommended	3/13/2003	12/01/2000
	(Includes Obtaining Grans) (Eg, 1 of Flerifiacial Microsoffia)	Clinical Review to avoid post-service review.		
21248	Reconstruction Of Mandible Or Maxilla, Endosteal Implant (Eg, Blade, Cylinder);	MP Criteria: Procedure/service reviewed against	5/15/2009	12/31/2999
21240	Partial	Medical Policy Criteria. Submit for Recommended	3/13/2009	12/31/2999
	Failiai	•		
21249	Reconstruction Of Mandible Or Maxilla, Endosteal Implant (Eg, Blade, Cylinder);	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	5/15/2009	12/31/2999
21249	, , ,		5/15/2009	12/31/2999
	Complete	Medical Policy Criteria. Submit for Recommended		
24605	Hyoid Myotomy And Suspension	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	11/1/2007	12/31/2999
21685	Hyold Myotomy And Suspension	•	11/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
21740	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Open	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
21740	Reconstructive Repair Of Pectus Excavatum Of Cannatum; Open		4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
24740	December 4th December 0f December 100 October 100 Minimally live 110 Income	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
21742	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Approach (Nuss Procedure), Without Thoracoscopy	Medical Policy Criteria. Submit for Recommended		
24740		Clinical Review to avoid post-service review.	4/4/0000	10/04/0000
21743	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Approach (Nuss Procedure), With Thoracoscopy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
22505	Manipulation Of Spine Requiring Anesthesia, Any Region	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
22526	Percutaneous Intradiscal Electrothermal Annuloplasty, Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Including Fluoroscopic Guidance; Single Level	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

22527	Percutaneous Intradiscal Electrothermal Annuloplasty, Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or More Additional Levels (List Separately In	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU	1/1/2023	12/31/2999
	Addition To Code For Primary Procedure)	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
22586	Arthrodesis, Pre-Sacral Interbody Technique, Including Disc Space Preparation, Discectomy, With Posterior Instrumentation, With Image Guidance, Includes Bone Graft When Performed, L5-S1 Interspace	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Graff When Performed, E5-51 interspace	Coding Policy (CPCP).		
22836	Anterior Thoracic Vertebral Body Tethering, Including Thoracoscopy, When	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Performed; Up To 7 Vertebral Segments	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
22837	Anterior Thoracic Vertebral Body Tethering, Including Thoracoscopy, When	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Performed; 8 Or More Vertebral Segments	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
22838	Revision (Eg, Augmentation, Division Of Tether), Replacement, Or Removal Of	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Thoracic Vertebral Body Tethering, Including Thoracoscopy, When Performed	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
22867	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
.2001	Without Fusion, Including Image Guidance When Performed, With Open	Not subject to pre-service review. Check EIU	17 172020	12/01/2000
	Decompression, Lumbar; Single Level	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Without Fusion, Including Image Guidance When Performed, With Open	Not subject to pre-service review. Check EIU		
	Decompression, Lumbar; Second Level (List Separately In Addition To Code For	policy, which is one of our Clinical Payment and		
	Primary Procedure)	Coding Policy (CPCP).		
22869	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Without Open Decompression Or Fusion, Including Image Guidance When	Not subject to pre-service review. Check EIU		
	Performed, Lumbar; Single Level	policy, which is one of our Clinical Payment and		
22870	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device,	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
.2010	Without Open Decompression Or Fusion, Including Image Guidance When	Not subject to pre-service review. Check EIU	17 172020	12/01/2000
	Performed, Lumbar; Second Level (List Separately In Addition To Code For	policy, which is one of our Clinical Payment and		
	Primary Procedure)	Coding Policy (CPCP).		
2899	Unlisted Procedure, Spine	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
23929	Unlisted Procedure, Shoulder	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1000	M : 10 FI	Clinical Review to avoid post-service review.	4/45/0040	40/04/0000
24300	Manipulation, Elbow, Under Anesthesia	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
25259	Manipulation Wrist Under Apaethosis	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
.JZJ8	Manipulation, Wrist, Under Anesthesia	Medical Policy Criteria. Submit for Recommended	1/13/2013	12/3/1/2999
		· ·		
	<u> </u>	Clinical Review to avoid post-service review.		

Manipulation, Finger Joint, Under Anesthesia, Each Joint	MP Criteria: Procedure/service reviewed against	1/15/2013	12/31/2999
	Medical Policy Criteria. Submit for Recommended		
	Clinical Review to avoid post-service review.		
Manipulation, Palmar Fascial Cord (le, Dupuytren'S Cord), Post Enzyme Injection	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
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Treatment Of Spontaneous Hip Dislocation (Developmental, Including Congenital		1/15/2013	12/31/2999
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• , , , , , , , , , , , , , , , , , , ,	1		
	MP Criteria: Procedure/service reviewed against	6/15/2015	12/31/2999
	Medical Policy Criteria. Submit for Recommended		
Arthrodesis, Sacroiliac Joint, Percutaneous, With Image Guidance, Including	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
Sovies[es]/, Thailean Flamen, and Sovies			
Unlisted Procedure, Pelvis Or Hip Joint		6/1/2017	12/31/2999
Arthroplasty, Ankle: With Implant (Total Ankle)		12/15/2009	12/31/2999
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	1		
Arthroplasty, Ankle: Revision, Total Ankle	<u> </u>	5/1/2015	12/31/2999
, , , ,			
Removal Of Ankle Implant	MP Criteria: Procedure/service reviewed against	5/1/2015	12/31/2999
	,		
Manipulation Of Ankle Under General Anesthesia (Includes Application Of Traction		1/15/2013	12/31/2999
,			
Extracorporeal Shock Wave, High Energy, Performed By A Physician Or Other		9/1/2020	12/31/2999
Qualified Health Care Professional, Requiring Anesthesia Other Than Local.			
	Coding Policy (CPCP).		
Arthroscopy, Hip. Surgical: With Debridement/Shaving Of Articular Cartilage	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
(Chondroplasty), Abrasion Arthroplasty, And/Or Resection Of Labrum	Medical Policy Criteria. Submit for Recommended		
(			
Arthroscopy, Knee, Surgical; Osteochondral Autograft(S) (Eg. Mosaicplasty)	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
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Arthroscopy, Knee, Surgical: Osteochondral Allograft (Eq. Mosaicplasty)		8/15/2007	12/31/2999
3 ( 3)	•		
	,		
Arthroscopy, Knee, Surgical; Meniscal Transplantation (Includes Arthrotomy For		8/15/2007	12/31/2999
Arthroscopy, Hip, Surgical; With Femoroplasty (le. Treatment Of Cam Lesion)		1/1/2011	12/31/2999
	Clinical Review to avoid post-service review.		
	(Eg, Collagenase), Single Cord  Treatment Of Spontaneous Hip Dislocation (Developmental, Including Congenital Or Pathological), By Abduction, Splint Or Traction; With Manipulation, Requiring Anesthesia  Manipulation, Hip Joint, Requiring General Anesthesia  Arthrodesis, Sacroiliac Joint, Percutaneous, With Image Guidance, Including Placement Of Intra-Articular Implant(S) (Eg, Bone Allograft[S], Synthetic Device[S]), Without Placement Of Transfixation Device  Unlisted Procedure, Pelvis Or Hip Joint  Arthroplasty, Ankle; With Implant (Total Ankle)  Removal Of Ankle Implant	Medical Policy Criterias Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criterias. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criterias. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criterias. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criterias. Submit for Recommended Clinical Review to avoid post-service reviewed Arthrodesis, Sacrolliac Joint, Percutaneous, With Image Guidance, Including Placement Of Intra-Articular Implant(S) (Eg. Bone Allograft(S), Synthetic Device(S)), Wilthout Placement Of Transfixation Device  Unlisted Procedure, Pelvis Or Hip Joint Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed Against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review Check Ell policy. Arthroscopy, Knee, Surgical; With Debridement/Shaving of Articular Cartilage (Chondroplasty), Abrasion Arthropiasty, And/Or Resection Of Labrum Cl	Elg. Collagenase), Single Cord

29915	Arthroscopy, Hip, Surgical; With Acetabuloplasty (le, Treatment Of Pincer Lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2011	12/31/2999
		Clinical Review to avoid post-service review.		
29916	Arthroscopy, Hip, Surgical; With Labral Repair	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9999	Unlisted Procedure, Arthroscopy	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
30468	Repair Of Nasal Valve Collapse With Subcutaneous/Submucosal Lateral Wall	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Implant(S)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
30469	Repair Of Nasal Valve Collapse With Low Energy, Temperature-Controlled (le,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Radiofrequency) Subcutaneous/Submucosal Remodeling	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
31242	Nasal/Sinus Endoscopy, Surgical; With Destruction By Radiofrequency Ablation,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Posterior Nasal Nerve	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
1243	Nasal/Sinus Endoscopy, Surgical; With Destruction By Cryoablation, Posterior	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Nasal Nerve	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
31295	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Maxillary	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
	Sinus Ostium, Transnasal Or Via Canine Fossa	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31298	Nasal/Sinus Endoscopy, Surgical, With Dilation (Eg, Balloon Dilation); Frontal And	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Sphenoid Sinus Ostia	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31573	Laryngoscopy, Flexible; With Therapeutic Injection(S) (Eg, Chemodenervation	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	Agent Or Corticosteroid, Injected Percutaneous, Transoral, Or Via Endoscope	Medical Policy Criteria. Submit for Recommended		
	Channel), Unilateral	Clinical Review to avoid post-service review.		
31574	Laryngoscopy, Flexible; With Injection(S) For Augmentation (Eg, Percutaneous,	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	Transoral), Unilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31627	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Performed; With Computer-Assisted, Image-Guided Navigation (List Separately In	Medical Policy Criteria. Submit for Recommended		
	Addition To Code For Primary Procedure[S])	Clinical Review to avoid post-service review.		
1634	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
-	Performed; With Balloon Occlusion, With Assessment Of Air Leak, With	Medical Policy Criteria. Submit for Recommended		
	Administration Of Occlusive Substance (Eg, Fibrin Glue), If Performed	Clinical Review to avoid post-service review.		
1647	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
· · · · ·	Performed; With Balloon Occlusion, When Performed, Assessment Of Air Leak,	Medical Policy Criteria. Submit for Recommended		12,0.,200
	Airway Sizing, And Insertion Of Bronchial Valve(S), Initial Lobe	Clinical Review to avoid post-service review.		
31648	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
,,,,,,	Performed; With Removal Of Bronchial Valve(S), Initial Lobe	Medical Policy Criteria. Submit for Recommended	5, 1,2020	12/01/2000
	Totalined, with removal of biolicilal valve(o), illinal cobe	Clinical Review to avoid post-service review.		
	I	Cililical Neview to avoid post-service review.	<u> </u>	

31649	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	12/1/2020	12/31/2999
	Performed; With Removal Of Bronchial Valve(S), Each Additional Lobe (List	Medical Policy Criteria. Submit for Recommended		
	Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
1651	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	12/1/2020	12/31/2999
	Performed; With Balloon Occlusion, When Performed, Assessment Of Air Leak,	Medical Policy Criteria. Submit for Recommended		
	Airway Sizing, And Insertion Of Bronchial Valve(S), Each Additional Lobe (List	Clinical Review to avoid post-service review.		
14000	Separately In Addition To Code For Primary Procedure[S])	NAD Ocitaria - December 1 - maior - maior - december 1	4/4/0040	40/04/0000
31660	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Performed; With Bronchial Thermoplasty, 1 Lobe	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
31661	Bronchoscopy, Rigid Or Flexible, Including Fluoroscopic Guidance, When	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
71001	Performed; With Bronchial Thermoplasty, 2 Or More Lobes	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/31/2999
	renomied, with brondinal memoplasty, 2 of More Lobes	Clinical Review to avoid post-service review.		
32553	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
,2000	Markers, Dosimeter), Percutaneous, Intra-Thoracic, Single Or Multiple	Medical Policy Criteria. Submit for Recommended	10/0/2010	12/01/2000
	markers, 200 meter), 1 ordatanosas, mila metaolo, oringio en matapie	Clinical Review to avoid post-service review.		
32664	Thoracoscopy, Surgical; With Thoracic Sympathectomy	MP Criteria: Procedure/service reviewed against	8/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
32994	Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S)	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Including Pleura Or Chest Wall When Involved By Tumor Extension,	Medical Policy Criteria. Submit for Recommended		
	Percutaneous, Including Imaging Guidance When Performed, Unilateral;	Clinical Review to avoid post-service review.		
	Cryoablation	·		
32998		MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	Including Pleura Or Chest Wall When Involved By Tumor Extension,	Medical Policy Criteria. Submit for Recommended		
	Percutaneous, Including Imaging Guidance When Performed, Unilateral;	Clinical Review to avoid post-service review.		
	Radiofrequency			
33211	Insertion Or Replacement Of Temporary Transvenous Dual Chamber Pacing	MP Criteria: Procedure/service reviewed against	2/1/2009	12/31/2999
	Electrodes (Separate Procedure)	Medical Policy Criteria. Submit for Recommended		
20042	Universities Of December Date of Consenting Only With Edition Death and	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
33213	Insertion Of Pacemaker Pulse Generator Only; With Existing Dual Leads	MP Criteria: Procedure/service reviewed against	2/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
33225	Insertion Of Pacing Electrode, Cardiac Venous System, For Left Ventricular	MP Criteria: Procedure/service reviewed against	2/1/2009	12/31/2999
00220	Pacing, At Time Of Insertion Of Implantable Defibrillator Or Pacemaker Pulse	Medical Policy Criteria. Submit for Recommended	2/1/2003	12/01/2000
	Generator (Eg, For Upgrade To Dual Chamber System) (List Separately In	Clinical Review to avoid post-service review.		
	Addition To Code For Primary Procedure)	Chillipan Neview to avoid post service review.		
33267	Exclusion Of Left Atrial Appendage, Open, Any Method (Eg, Excision, Isolation Via	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	Stapling, Oversewing, Ligation, Plication, Clip)	Medical Policy Criteria. Submit for Recommended		12/01/2000
	Josephing, Oversooning, Eigeneri, Finesticit, Cirp)	Clinical Review to avoid post-service review.		
33268	Exclusion Of Left Atrial Appendage, Open, Performed At The Time Of Other	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
-	Sternotomy Or Thoracotomy Procedure(S), Any Method (Eg, Excision, Isolation	Medical Policy Criteria. Submit for Recommended		
	Via Stapling, Oversewing, Ligation, Plication, Clip) (List Separately In Addition To	Clinical Review to avoid post-service review.		
	Code For Primary Procedure)	, , , , , , , , , , , , , , , , , , , ,		
33269	Exclusion Of Left Atrial Appendage, Thoracoscopic, Any Method (Eg, Excision,	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	Isolation Via Stapling, Oversewing, Ligation, Plication, Clip)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

33270	Insertion Or Replacement Of Permanent Subcutaneous Implantable Defibrillator System, With Subcutaneous Electrode, Including Defibrillation Threshold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2015	12/31/2999
	Evaluation, Induction Of Arrhythmia, Evaluation Of Sensing For Arrhythmia Termination, And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters, When Performed	Clinical Review to avoid post-service review.		
33271	Insertion Of Subcutaneous Implantable Defibrillator Electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
33274	Transcatheter Insertion Or Replacement Of Permanent Leadless Pacemaker, Right Ventricular, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Ventriculography, Femoral Venography) And Device Evaluation (Eg, Interrogation Or Programming), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
33275	Transcatheter Removal Of Permanent Leadless Pacemaker, Right Ventricular, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Ventriculography, Femoral Venography), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2020	12/31/2999
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]), Including Vessel Catheterization, All Imaging Guidance, And Pulse Generator Initial Analysis With Diagnostic Mode Activation, When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33278	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; System, Including Pulse Generator And Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33279	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33280	Removal Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Pulse Generator Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33285	Insertion, Subcutaneous Cardiac Rhythm Monitor, Including Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
33287	Removal And Replacement Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Pulse Generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
33288	Removal And Replacement Of Phrenic Nerve Stimulator, Including Vessel Catheterization, All Imaging Guidance, And Interrogation And Programming, When Performed; Transvenous Stimulation Or Sensing Lead(S)	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999

33289	Transcatheter Implantation Of Wireless Pulmonary Artery Pressure Sensor For Long-Term Hemodynamic Monitoring, Including Deployment And Calibration Of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2019	12/31/2999
	The Sensor, Right Heart Catheterization, Selective Pulmonary Catheterization,	Clinical Review to avoid post-service review.		
	Radiological Supervision And Interpretation, And Pulmonary Artery Angiography, When Performed			
3340	Percutaneous Transcatheter Closure Of The Left Atrial Appendage With	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	Endocardial Implant, Including Fluoroscopy, Transseptal Puncture, Catheter	Medical Policy Criteria. Submit for Recommended		
	Placement(S), Left Atrial Angiography, Left Atrial Appendage Angiography, When	Clinical Review to avoid post-service review.		
	Performed, And Radiological Supervision And Interpretation	·		
3361	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Percutaneous Femoral Artery Approach	Medical Policy Criteria. Submit for Recommended		
	, "	Clinical Review to avoid post-service review.		
3362	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Femoral Artery Approach	Medical Policy Criteria. Submit for Recommended		
	, "	Clinical Review to avoid post-service review.		
3363	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
-	Axillary Artery Approach	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
3364	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	Iliac Artery Approach	Medical Policy Criteria. Submit for Recommended		12/01/2000
	mac 7 ttory 7 pprodott	Clinical Review to avoid post-service review.		
3365	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
3000	Transaortic Approach (Eg, Median Sternotomy, Mediastinotomy)	Medical Policy Criteria. Submit for Recommended	11/1/2010	12/01/2000
	Transactae Approach (Eg, Median Sternetomy, Mediastinsterny)	Clinical Review to avoid post-service review.		
3366	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
0000	Transapical Exposure (Eg, Left Thoracotomy)	Medical Policy Criteria. Submit for Recommended	17 172014	12/01/2000
	Transapidal Exposure (Eg. Left Thoracotomy)	Clinical Review to avoid post-service review.		
3367	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
0007	Cardiopulmonary Bypass Support With Percutaneous Peripheral Arterial And	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
	Venous Cannulation (Eg, Femoral Vessels) (List Separately In Addition To Code	Clinical Review to avoid post-service review.		
	For Primary Procedure)	Cliffical Neview to avoid post-service review.		
3368	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
3300	Cardiopulmonary Bypass Support With Open Peripheral Arterial And Venous	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/01/2000
	Cannulation (Eg, Femoral, Iliac, Axillary Vessels) (List Separately In Addition To	Clinical Review to avoid post-service review.		
	Code For Primary Procedure)	Cliffical Neview to avoid post-service review.		
3369	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve;	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
0000	Cardiopulmonary Bypass Support With Central Arterial And Venous Cannulation	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/01/2000
	(Eg, Aorta, Right Atrium, Pulmonary Artery) (List Separately In Addition To Code	Clinical Review to avoid post-service review.		
	For Primary Procedure)	Cliffical Neview to avoid post-service review.		
3418	Transcatheter Mitral Valve Repair, Percutaneous Approach, Including Transseptal	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
U <del>-1</del> 10	Puncture When Performed; Initial Prosthesis	Medical Policy Criteria. Submit for Recommended	2/ 13/2010	12/3/1/2333
	Functure when renormed, initial riostresis	II		
3419	Transcatheter Mitral Valve Repair, Percutaneous Approach, Including Transseptal	Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
3419		MP Criteria: Procedure/service reviewed against	2/13/2016	12/31/2999
	Puncture When Performed; Additional Prosthesis(Es) During Same Session (List	Medical Policy Criteria. Submit for Recommended		
0.477	Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
3477	Transcatheter Pulmonary Valve Implantation, Percutaneous Approach, Including	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	Pre-Stenting Of The Valve Delivery Site, When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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33982		MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	Single Ventricle, Without Cardiopulmonary Bypass	Medical Policy Criteria. Submit for Recommended		
20000		Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
33983		MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	Single Ventricle, With Cardiopulmonary Bypass	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	4440040	10/01/0000
33990	Insertion Of Ventricular Assist Device, Percutaneous, Including Radiological	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Supervision And Interpretation; Left Heart, Arterial Access Only	Medical Policy Criteria. Submit for Recommended		
00004		Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
33991	Insertion Of Ventricular Assist Device, Percutaneous, Including Radiological	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Supervision And Interpretation; Left Heart, Both Arterial And Venous Access, With	1		
	Transseptal Puncture	Clinical Review to avoid post-service review.		
33992		MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	And Venous Cannula(S), At Separate And Distinct Session From Insertion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33993	· · · · · · · · · · · · · · · · · · ·	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Imaging Guidance At Separate And Distinct Session From Insertion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33999	Unlisted Procedure, Cardiac Surgery	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36260	Insertion Of Implantable Intra-Arterial Infusion Pump (Eg, For Chemotherapy Of	MP Criteria: Procedure/service reviewed against	3/1/2007	12/31/2999
	Liver)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36465	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Maneuvers To Guide Dispersion Of The Injectate, Inclusive Of All Imaging	Medical Policy Criteria. Submit for Recommended		
	Guidance And Monitoring; Single Incompetent Extremity Truncal Vein (Eg, Great	Clinical Review to avoid post-service review.		
	Saphenous Vein, Accessory Saphenous Vein)			
36466	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Guidance And Monitoring; Multiple Incompetent Truncal Veins (Eg, Great	Clinical Review to avoid post-service review.		
	Saphenous Vein, Accessory Saphenous Vein), Same Leg			
36468	Injection(S) Of Sclerosant For Spider Veins (Telangiectasia), Limb Or Trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36470	Injection Of Sclerosant; Single Incompetent Vein (Other Than Telangiectasia)	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36471	Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia),	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Same Leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36473	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
36474	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

36475	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Radiofrequency; First Vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2005	12/31/2999
36476	Treated  Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Radiofrequency; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
36478	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Laser; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
36479	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous, Laser; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
36482	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, By Transcatheter Delivery Of A Chemical Adhesive (Eg, Cyanoacrylate) Remote From The Access Site, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous; First Vein Treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36483	Endovenous Ablation Therapy Of Incompetent Vein, Extremity, By Transcatheter Delivery Of A Chemical Adhesive (Eg, Cyanoacrylate) Remote From The Access Site, Inclusive Of All Imaging Guidance And Monitoring, Percutaneous; Subsequent Vein(S) Treated In A Single Extremity, Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36511	Therapeutic Apheresis; For White Blood Cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
36522	Photopheresis, Extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
36563	Insertion Of Tunneled Centrally Inserted Central Venous Access Device With Subcutaneous Pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
36836	Percutaneous Arteriovenous Fistula Creation, Upper Extremity, Single Access Of Both The Peripheral Artery And Peripheral Vein, Including Fistula Maturation Procedures (Eg, Transluminal Balloon Angioplasty, Coil Embolization) When Performed, Including All Vascular Access, Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
36837	Percutaneous Arteriovenous Fistula Creation, Upper Extremity, Separate Access Sites Of The Peripheral Artery And Peripheral Vein, Including Fistula Maturation Procedures (Eg, Transluminal Balloon Angioplasty, Coil Embolization) When Performed, Including All Vascular Access, Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
37215	Transcatheter Placement Of Intravascular Stent(S), Cervical Carotid Artery, Open Or Percutaneous, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation; With Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
37216	Transcatheter Placement Of Intravascular Stent(S), Cervical Carotid Artery, Open Or Percutaneous, Including Angioplasty, When Performed, And Radiological Supervision And Interpretation; Without Distal Embolic Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

37217	Transcatheter Placement Of Intravascular Stent(S), Intrathoracic Common Carotid	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
	Artery Or Innominate Artery By Retrograde Treatment, Open Ipsilateral Cervical	Medical Policy Criteria. Submit for Recommended		
	Carotid Artery Exposure, Including Angioplasty, When Performed, And	Clinical Review to avoid post-service review.		
	Radiological Supervision And Interpretation	· ·		
218	Transcatheter Placement Of Intravascular Stent(S), Intrathoracic Common Carotid	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	Artery Or Innominate Artery, Open Or Percutaneous Antegrade Approach,	Medical Policy Criteria. Submit for Recommended		
	Including Angioplasty, When Performed, And Radiological Supervision And	Clinical Review to avoid post-service review.		
	Interpretation			
241	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary	Medical Policy Criteria. Submit for Recommended		
	To Complete The Intervention; Venous, Other Than Hemorrhage (Eg, Congenital	Clinical Review to avoid post-service review.		
	Or Acquired Venous Malformations, Venous And Capillary Hemangiomas, Varices,	· ·		
	Varicoceles)			
242		MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary	Medical Policy Criteria. Submit for Recommended		
	To Complete The Intervention; Arterial, Other Than Hemorrhage Or Tumor (Eg,	Clinical Review to avoid post-service review.		
	Congenital Or Acquired Arterial Malformations, Arteriovenous Malformations,	,		
	Arteriovenous Fistulas, Aneurvsms, Pseudoaneurvsms)			
243		MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary	Medical Policy Criteria. Submit for Recommended		
	To Complete The Intervention; For Tumors, Organ Ischemia, Or Infarction	Clinical Review to avoid post-service review.		
		F		
244	Vascular Embolization Or Occlusion, Inclusive Of All Radiological Supervision And	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Interpretation, Intraprocedural Roadmapping, And Imaging Guidance Necessary	Medical Policy Criteria. Submit for Recommended		
	To Complete The Intervention; For Arterial Or Venous Hemorrhage Or Lymphatic	Clinical Review to avoid post-service review.		
	Extravasation	'		
500	Vascular Endoscopy, Surgical, With Ligation Of Perforator Veins, Subfascial	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	(Seps)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction, Or	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Distal Interruptions	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
718	Ligation, Division, And Stripping, Short Saphenous Vein	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins From	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Saphenofemoral Junction To Knee Or Below	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	With Radical Excision Of Ulcer And Skin Graft And/Or Interruption Of	Medical Policy Criteria. Submit for Recommended		
	Communicating Veins Of Lower Leg, With Excision Of Deep Fascia	Clinical Review to avoid post-service review.		
760	Ligation Of Perforator Veins, Subfascial, Radical (Linton Type), Including Skin	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Graft, When Performed, Open,1 Leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
761	Ligation Of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance,	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	When Performed, 1 Leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	The state of the s	Medical Policy Criteria. Submit for Recommended		12,0 ,, 2000

37766	Stab Phlebectomy Of Varicose Veins, 1 Extremity; More Than 20 Incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2004	12/31/2999
		Clinical Review to avoid post-service review.		
37780	Ligation And Division Of Short Saphenous Vein At Saphenopopliteal Junction	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	(Separate Procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37785	Ligation, Division, And/Or Excision Of Varicose Vein Cluster(S), 1 Leg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37788	Penile Revascularization, Artery, With Or Without Vein Graft	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	, ,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37790	Penile Venous Occlusive Procedure	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
000		Medical Policy Criteria. Submit for Recommended	2, . 0, 200.	12/01/2000
		Clinical Review to avoid post-service review.		
38204	Management Of Recipient Hematopoietic Progenitor Cell Donor Search And Cell	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
00207	Acquisition	Medical Policy Criteria. Submit for Recommended	112112009	12/01/2000
	Acquisition			
38205	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation, Per	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
30203			1/21/2009	12/31/2999
	Collection; Allogeneic	Medical Policy Criteria. Submit for Recommended		
2002	T 1 1 D C 0111 1 1 C D T 0 H 0	Clinical Review to avoid post-service review.	7/07/0000	10/01/0000
38207	Transplant Preparation Of Hematopoietic Progenitor Cells; Cryopreservation And	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Storage	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38208	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Frozen Harvest, Without Washing, Per Donor	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38209	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Frozen Harvest, With Washing, Per Donor	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38210	Transplant Preparation Of Hematopoietic Progenitor Cells; Specific Cell Depletion	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Within Harvest, T-Cell Depletion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38211	Transplant Preparation Of Hematopoietic Progenitor Cells; Tumor Cell Depletion	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38212	Transplant Preparation Of Hematopoietic Progenitor Cells; Red Blood Cell	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Removal	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38213	Transplant Preparation Of Hematopoietic Progenitor Cells; Platelet Depletion	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Transplant Population of Floridaepoisto Progetime Cone, Floridae Depisite.	Medical Policy Criteria. Submit for Recommended	1,21,2000	1.2,0.7,2000
		Clinical Review to avoid post-service review.		
38214	Transplant Preparation Of Hematopoietic Progenitor Cells; Plasma (Volume)	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
00 <u>-</u> 17	Depletion	Medical Policy Criteria. Submit for Recommended	.72172000	12/01/2000
	σοριστίστ	Clinical Review to avoid post-service review.		
38215	Transplant Preparation Of Hematopoietic Progenitor Cells; Cell Concentration In	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
30213		· ·	112112009	12/31/2999
	Plasma, Mononuclear, Or Buffy Coat Layer	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

38232	Bone Marrow Harvesting For Transplantation; Autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2012	12/31/2999
		Clinical Review to avoid post-service review.		
38240	Hematopoietic Progenitor Cell (Hpc); Allogeneic Transplantation Per Donor	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
30240	Trematopolette i Togerittor Oeii (Tipo), Allogeriete Transplantation i et Bonoi	Medical Policy Criteria. Submit for Recommended	1/21/2005	12/01/2000
		Clinical Review to avoid post-service review.		
38242	Allogeneic Lymphocyte Infusions	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
30242	Allogoricio Lymphocyte illiusions	Medical Policy Criteria. Submit for Recommended	1/21/2005	12/01/2000
		Clinical Review to avoid post-service review.		
38243	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
00240	The matopoletic in togethic Cell (Tipe), Tipe Boost	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/3/1/2999
		Clinical Review to avoid post-service review.		
38308	Lymphangiotomy Or Other Operations On Lymphatic Channels	MP Criteria: Procedure/service reviewed against	12/1/2014	12/31/2999
30300	Lymphangiotomy of other operations on Lymphatic chamiles	Medical Policy Criteria. Submit for Recommended	12/1/2014	12/3/1/2999
		Clinical Review to avoid post-service review.		
41120	Glossectomy; Less Than One-Half Tongue	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
+1120	Glossectorry, Less Than One-Hall Torigue	Medical Policy Criteria. Submit for Recommended	1/1/2006	12/31/2999
41512	Tongue Base Suspension, Permanent Suture Technique	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
41312	Torigue base Suspension, Permanent Suture Technique		1/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
44500	Outhorized Attacking Of The Transport Beat Section 2014 Annual October Beat	Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
41530	Submucosal Ablation Of The Tongue Base, Radiofrequency, 1 Or More Sites, Per	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Session	Medical Policy Criteria. Submit for Recommended		
10110		Clinical Review to avoid post-service review.	40/45/0000	40/04/0000
42140	Uvulectomy, Excision Of Uvula	MP Criteria: Procedure/service reviewed against	12/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10115		Clinical Review to avoid post-service review.	4444050	40/04/0000
42145	Palatopharyngoplasty (Eg, Uvulopalatopharyngoplasty, Uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
42950	Pharyngoplasty (Plastic Or Reconstructive Operation On Pharynx)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43192	Esophagoscopy, Rigid, Transoral; With Directed Submucosal Injection(S), Any	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Substance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43201	Esophagoscopy, Flexible, Transoral; With Directed Submucosal Injection(S), Any	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
	Substance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43206	Esophagoscopy, Flexible, Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
43210	Esophagogastroduodenoscopy, Flexible, Transoral; With Esophagogastric	MP Criteria: Procedure/service reviewed against	7/15/2016	12/31/2999
	Fundoplasty, Partial Or Complete, Includes Duodenoscopy When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43236	Esophagogastroduodenoscopy, Flexible, Transoral; With Directed Submucosal	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
	Injection(S), Any Substance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

43252		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU	9/1/2020	12/31/2999
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
43253	Esophagogastroduodenoscopy, Flexible, Transoral; With Transendoscopic Ultrasound-Guided Transmural Injection Of Diagnostic Or Therapeutic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2014	12/31/2999
	Substance(S) (Eg, Anesthetic, Neurolytic Agent) Or Fiducial Marker(S) (Includes	Clinical Review to avoid post-service review.		
	Endoscopic Ultrasound Examination Of The Esophagus, Stomach, And Either The			
	Duodenum Or A Surgically Altered Stomach Where The Jejunum Is Examined Distal To The Anastomosis)			
43257	Esophagogastroduodenoscopy, Flexible, Transoral; With Delivery Of Thermal	MP Criteria: Procedure/service reviewed against	5/1/2010	12/31/2999
	Energy To The Muscle Of Lower Esophageal Sphincter And/Or Gastric Cardia, For	Medical Policy Criteria. Submit for Recommended		
	Treatment Of Gastroesophageal Reflux Disease	Clinical Review to avoid post-service review.		
43284	Laparoscopy, Surgical, Esophageal Sphincter Augmentation Procedure,	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	Placement Of Sphincter Augmentation Device (le, Magnetic Band), Including	Medical Policy Criteria. Submit for Recommended		
	Cruroplasty When Performed	Clinical Review to avoid post-service review.		
43285	Removal Of Esophageal Sphincter Augmentation Device	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43289	Unlisted Laparoscopy Procedure, Esophagus	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43290	Esophagogastroduodenoscopy, Flexible, Transoral; With Deployment Of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Intragastric Bariatric Balloon	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
43291		EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Bariatric Balloon(S)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
43312	Esophagoplasty (Plastic Repair Or Reconstruction), Thoracic Approach; With	MP Criteria: Procedure/service reviewed against	8/15/2011	12/31/2999
	Repair Of Tracheoesophageal Fistula	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43632	Gastrectomy, Partial, Distal; With Gastrojejunostomy	MP Criteria: Procedure/service reviewed against	6/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43633	Gastrectomy, Partial, Distal; With Roux-En-Y Reconstruction	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43644	Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Roux-En-Y Gastroenterostomy (Roux Limb 150 Cm Or Less)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43645	Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
	Small Intestine Reconstruction To Limit Absorption	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure; Placement Of Adjustable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Gastric Restrictive Device (Eg, Gastric Band And Subcutaneous Port	Medical Policy Criteria. Submit for Recommended		
	Components)	Clinical Review to avoid post-service review.		

43771	Laparoscopy, Surgical, Gastric Restrictive Procedure; Revision Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2006	12/31/2999
43772	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal Of Adjustable	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Gastric Restrictive Device Component Only	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
13773	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal And Replacement Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
13774	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device And Subcutaneous Port Components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43775	Laparoscopy, Surgical, Gastric Restrictive Procedure; Longitudinal Gastrectomy (Ie, Sleeve Gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
43842	Gastric Restrictive Procedure, Without Gastric Bypass, For Morbid Obesity; Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43843	Gastric Restrictive Procedure, Without Gastric Bypass, For Morbid Obesity; Other Than Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43845	Gastric Restrictive Procedure With Partial Gastrectomy, Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50 To 100 Cm Common Channel) To Limit Absorption (Biliopancreatic Diversion With Duodenal Switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2009	12/31/2999
43846	Gastric Restrictive Procedure, With Gastric Bypass For Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-Y Gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
13847	Gastric Restrictive Procedure, With Gastric Bypass For Morbid Obesity; With Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43848	Revision, Open, Of Gastric Restrictive Procedure For Morbid Obesity, Other Than Adjustable Gastric Restrictive Device (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43860	Revision Of Gastrojejunal Anastomosis (Gastrojejunostomy) With Reconstruction, With Or Without Partial Gastrectomy Or Intestine Resection; Without Vagotomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2022	12/31/2999
13886	Gastric Restrictive Procedure, Open; Revision Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43887	Gastric Restrictive Procedure, Open; Removal Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43888	Gastric Restrictive Procedure, Open; Removal And Replacement Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
44640	Closure Of Intestinal Cutaneous Fistula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2011	12/31/2999

44705	Preparation Of Fecal Microbiota For Instillation, Including Assessment Of Donor Specimen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
46707	Repair Of Anorectal Fistula With Plug (Eg, Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
47370	Laparoscopy, Surgical, Ablation Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
47380	Ablation, Open, Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
47381	Ablation, Open, Of 1 Or More Liver Tumor(S); Cryosurgical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
47382	Ablation, 1 Or More Liver Tumor(S), Percutaneous, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
49411	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Percutaneous, Intra-Abdominal, Intra-Pelvic (Except Prostate), And/Or Retroperitoneum, Single Or Multiple	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
49412	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg, Fiducial Markers, Dosimeter), Open, Intra-Abdominal, Intrapelvic, And/Or Retroperitoneum, Including Image Guidance, If Performed, Single Or Multiple (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/3/2016	12/31/2999
50250	Ablation, Open, 1 Or More Renal Mass Lesion(S), Cryosurgical, Including Intraoperative Ultrasound Guidance And Monitoring, If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
50360	Renal Allotransplantation, Implantation Of Graft; Without Recipient Nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2017	12/31/2999
50541	Laparoscopy, Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
50542	Laparoscopy, Surgical; Ablation Of Renal Mass Lesion(S), Including Intraoperative Ultrasound Guidance And Monitoring, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
50592	Ablation, 1 Or More Renal Tumor(S), Percutaneous, Unilateral, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
50593	Ablation, Renal Tumor(S), Unilateral, Percutaneous, Cryotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
51715	Endoscopic Injection Of Implant Material Into The Submucosal Tissues Of The Urethra And/Or Bladder Neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999

52284	Cystourethroscopy, With Mechanical Urethral Dilation And Urethral Therapeutic	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis, Male, Including Fluoroscopy, When Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).	11110010	10/01/0000
52287	Cystourethroscopy, With Injection(S) For Chemodenervation Of The Bladder	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
52327	Cystourethroscopy (Including Ureteral Catheterization); With Subureteric Injection	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
	Of Implant Material	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
52441	Cystourethroscopy, With Insertion Of Permanent Adjustable Transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
	Implant; Single Implant	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
52442	Cystourethroscopy, With Insertion Of Permanent Adjustable Transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
	Implant; Each Additional Permanent Adjustable Transprostatic Implant (List	Medical Policy Criteria. Submit for Recommended		
	Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
53451	Periurethral Transperineal Adjustable Balloon Continence Device; Bilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Insertion, Including Cystourethroscopy And Imaging Guidance	Not subject to pre-service review. Check EIU		
	, 32, 1, 33	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
53452	Periurethral Transperineal Adjustable Balloon Continence Device; Unilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Insertion, Including Cystourethroscopy And Imaging Guidance	Not subject to pre-service review. Check EIU		
	moonion, monaining operation occupy, rank managing outlands	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
53453	Periurethral Transperineal Adjustable Balloon Continence Device; Removal, Each	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Balloon	Not subject to pre-service review. Check EIU	, .,	.2,0.,2000
	Buildon	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
53454	Periurethral Transperineal Adjustable Balloon Continence Device; Percutaneous	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
30404	Adjustment Of Balloon(S) Fluid Volume	Not subject to pre-service review. Check EIU	10/1/2024	12/01/2000
	Adjustitient Of Balloon(S) Fluid Volume	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
53855	Insertion Of A Temporary Prostatic Urethral Stent, Including Urethral Measurement	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
)3033	Insertion of A Temporary Frostatic oretinal Sterit, including oretinal Measurement	Not subject to pre-service review. Check EIU	3/13/2024	12/31/2999
		policy, which is one of our Clinical Payment and		
53860	Transurethral Radiofrequency Micro-Remodeling Of The Female Bladder Neck	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
03000	And Proximal Urethra For Stress Urinary Incontinence	Not subject to pre-service review. Check EIU	12/15/2014	12/31/2999
	And Proximal Oreuna For Stress Officially incontinence			
		policy, which is one of our Clinical Payment and		
1110	Evaluion Of Panilla Planua (Paymania Piagasa):	Coding Policy (CPCP).	0/5/0040	40/04/0000
54110	Excision Of Penile Plaque (Peyronie Disease);	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
-1111	Fusicion Of Davilla Diagna (Parmania Diagna) Mills On A.T. 5 On J. 1	Clinical Review to avoid post-service review.	0/5/0040	40/04/0000
54111	Excision Of Penile Plaque (Peyronie Disease); With Graft To 5 Cm In Length	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	0/5/00/15	10/04/5555
54112	Excision Of Penile Plaque (Peyronie Disease); With Graft Greater Than 5 Cm In	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
	Length	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	<u> </u>	

54125	Amputation Of Penis; Complete	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4200	Injection Procedure For Peyronie Disease;	MP Criteria: Procedure/service reviewed against	12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4205	Injection Procedure For Peyronie Disease; With Surgical Exposure Of Plaque	MP Criteria: Procedure/service reviewed against	12/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4235	Injection Of Corpora Cavernosa With Pharmacologic Agent(S) (Eg, Papaverine,	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	Phentolamine)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4240	Penile Plethysmography	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4360	Plastic Operation On Penis To Correct Angulation	MP Criteria: Procedure/service reviewed against	3/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4400	Insertion Of Penile Prosthesis; Non-Inflatable (Semi-Rigid)	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1401	Insertion Of Penile Prosthesis; Inflatable (Self-Contained)	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4405	Insertion Of Multi-Component, Inflatable Penile Prosthesis, Including Placement Of	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
	Pump, Cylinders, And Reservoir	Medical Policy Criteria. Submit for Recommended		1
	,, <del>,</del> ,, ,, ,, ,, ,	Clinical Review to avoid post-service review.		
4406	Removal Of All Components Of A Multi-Component, Inflatable Penile Prosthesis	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
	Without Replacement Of Prosthesis	Medical Policy Criteria. Submit for Recommended		
	Thinest replacement of a resultance	Clinical Review to avoid post-service review.		
4408	Repair Of Component(S) Of A Multi-Component, Inflatable Penile Prosthesis	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	Topan of compensin(o) of it main compensin, innanasis i cinic i recinicis	Medical Policy Criteria. Submit for Recommended	_,	. = / 0 . / = 000
		Clinical Review to avoid post-service review.		
4410	Removal And Replacement Of All Component(S) Of A Multi-Component, Inflatable	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	Penile Prosthesis At The Same Operative Session	Medical Policy Criteria. Submit for Recommended	2, 10, 200,	12/01/2000
	Total Tookhoolo 7 k The outlie operative decolor	Clinical Review to avoid post-service review.		
4411	Removal And Replacement Of All Components Of A Multi-Component Inflatable	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
7-711	Penile Prosthesis Through An Infected Field At The Same Operative Session,	Medical Policy Criteria. Submit for Recommended	2/10/2007	12/01/2000
	Including Irrigation And Debridement Of Infected Tissue	Clinical Review to avoid post-service review.		
1415	Removal Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
++15	Prosthesis, Without Replacement Of Prosthesis	Medical Policy Criteria. Submit for Recommended	2/13/2007	12/3 1/2999
	1 Tostilesis, Without Neplacement Of 1 Tostilesis	Clinical Review to avoid post-service review.		
1416	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
14 10	Contained) Penile Prosthesis At The Same Operative Session	Medical Policy Criteria. Submit for Recommended	2/13/2007	12/31/2999
	Outrained) Fellie Flostiesis At The Sallie Operative Session	1	1	
4417	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-	Clinical Review to avoid post-service review.	2/15/2007	12/31/2999
++ 1 /		MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	Contained) Penile Prosthesis Through An Infected Field At The Same Operative	Medical Policy Criteria. Submit for Recommended	1	
1110	Session, Including Irrigation And Debridement Of Infected Tissue	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
1440	Plastic Operation Of Penis For Injury	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		

54660	Insertion Of Testicular Prosthesis (Separate Procedure)	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55400	Vasovasostomy, Vasovasorrhaphy	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
55706	Biopsies, Prostate, Needle, Transperineal, Stereotactic Template Guided	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
	Saturation Sampling, Including Imaging Guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55870	Electroejaculation	Non Covered: Procedure/service not covered by	11/1/2015	12/31/2999
		the Plan. Not subject to pre-service review.		
55873	Cryosurgical Ablation Of The Prostate (Includes Ultrasonic Guidance And	MP Criteria: Procedure/service reviewed against	6/15/2007	12/31/2999
	Monitoring)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55880	Ablation Of Malignant Prostate Tissue, Transrectal, With High Intensity-Focused	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	Ultrasound (Hifu), Including Ultrasound Guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55970	Intersex Surgery; Male To Female	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55980	Intersex Surgery; Female To Male	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
56805	Clitoroplasty For Intersex State	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
56810	Perineoplasty, Repair Of Perineum, Nonobstetrical (Separate Procedure)	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57291	Construction Of Artificial Vagina; Without Graft	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57292	Construction Of Artificial Vagina; With Graft	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57295	Revision (Including Removal) Of Prosthetic Vaginal Graft; Vaginal Approach	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57296	Revision (Including Removal) Of Prosthetic Vaginal Graft; Open Abdominal	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	Approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57307	Closure Of Rectovaginal Fistula; Abdominal Approach, With Concomitant	MP Criteria: Procedure/service reviewed against	8/15/2011	12/31/2999
	Colostomy	Medical Policy Criteria. Submit for Recommended	0, 10, 20 11	12,01,200
		Clinical Review to avoid post-service review.		
57335	Vaginoplasty For Intersex State	MP Criteria: Procedure/service reviewed against	4/1/2008	12/31/2999
	gsp.usty . St. Microsoft State	Medical Policy Criteria. Submit for Recommended	1	1.2,5.,2000
		Clinical Review to avoid post-service review.		
57426	Revision (Including Removal) Of Prosthetic Vaginal Graft, Laparoscopic Approach	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
J1 720	Trevision (moluting tremoval) On Hostiletic vaginal Orali, Lapatoscopic Approach	Medical Policy Criteria. Submit for Recommended	1/1/2010	12/3/1/2333
		Clinical Review to avoid post-service review.		

58321	Artificial Insemination; Intra-Cervical	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58322	Artificial Insemination; Intra-Uterine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58323	Sperm Washing For Artificial Insemination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58580	Transcervical Ablation Of Uterine Fibroid(S), Including Intraoperative Ultrasound Guidance And Monitoring, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
58674	Laparoscopy, Surgical, Ablation Of Uterine Fibroid(S) Including Intraoperative Ultrasound Guidance And Monitoring, Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
58750	Tubotubal Anastomosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58752	Tubouterine Implantation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58970	Follicle Puncture For Oocyte Retrieval, Any Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58974	Embryo Transfer, Intrauterine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58976	Gamete, Zygote, Or Embryo Intrafallopian Transfer, Any Method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
59072	Fetal Umbilical Cord Occlusion, Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
59074	Fetal Fluid Drainage (Eg, Vesicocentesis, Thoracocentesis, Paracentesis), Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
59076	Fetal Shunt Placement, Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2012	12/31/2999
59897	Unlisted Fetal Invasive Procedure, Including Ultrasound Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
60699	Unlisted Procedure, Endocrine System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
61215	Insertion Of Subcutaneous Reservoir, Pump Or Continuous Infusion System For Connection To Ventricular Catheter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
61630	Balloon Angioplasty, Intracranial (Eg, Atherosclerotic Stenosis), Percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
61635	Transcatheter Placement Of Intravascular Stent(S), Intracranial (Eg, Atherosclerotic Stenosis), Including Balloon Angioplasty, If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999

31645	Percutaneous Arterial Transluminal Mechanical Thrombectomy And/Or Infusion	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	For Thrombolysis, Intracranial, Any Method, Including Diagnostic Angiography,	Medical Policy Criteria. Submit for Recommended		
	Fluoroscopic Guidance, Catheter Placement, And Intraprocedural Pharmacological			
	Thrombolytic Injection(S)	Common review to avoid post corvice review.		
650	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S)	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	Other Than For Thrombolysis, Arterial, Including Catheter Placement, Diagnostic	Medical Policy Criteria. Submit for Recommended		
	Angiography, And Imaging Guidance; Initial Vascular Territory	Clinical Review to avoid post-service review.		
651	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S)	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	Other Than For Thrombolysis, Arterial, Including Catheter Placement, Diagnostic	Medical Policy Criteria. Submit for Recommended		
	Angiography, And Imaging Guidance; Each Additional Vascular Territory (List	Clinical Review to avoid post-service review.		
	Separately In Addition To Code For Primary Procedure)	'		
736	Laser Interstitial Thermal Therapy (Litt) Of Lesion, Intracranial, Including Burr	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	Hole(S), With Magnetic Resonance Imaging Guidance, When Performed; Single	Medical Policy Criteria. Submit for Recommended		
	Trajectory For 1 Simple Lesion	Clinical Review to avoid post-service review.		
737	Laser Interstitial Thermal Therapy (Litt) Of Lesion, Intracranial, Including Burr	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	Hole(S), With Magnetic Resonance Imaging Guidance, When Performed; Multiple	Medical Policy Criteria. Submit for Recommended		
	Trajectories For Multiple Or Complex Lesion(S)	Clinical Review to avoid post-service review.		
783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	In Addition To Code For Primary Procedure)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
889	Insertion Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Including Craniectomy Or Craniotomy, When Performed, With Direct Or Inductive	Medical Policy Criteria. Submit for Recommended		
	Coupling, With Connection To Depth And/Or Cortical Strip Electrode Array(S)	Clinical Review to avoid post-service review.		
891	Revision Or Replacement Of Skull-Mounted Cranial Neurostimulator Pulse	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Generator Or Receiver With Connection To Depth And/Or Cortical Strip Electrode	Medical Policy Criteria. Submit for Recommended		
	Array(S)	Clinical Review to avoid post-service review.		
1892	Removal Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	With Cranioplasty, When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2263	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	Hypertonic Saline, Enzyme) Or Mechanical Means (Eg, Catheter) Including	Not subject to pre-service review. Check EIU		
	Radiologic Localization (Includes Contrast When Administered), Multiple	policy, which is one of our Clinical Payment and		
	Adhesiolysis Sessions; 2 Or More Days	Coding Policy (CPCP).		
2264	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	Hypertonic Saline, Enzyme) Or Mechanical Means (Eg, Catheter) Including	Not subject to pre-service review. Check EIU		
	Radiologic Localization (Includes Contrast When Administered), Multiple	policy, which is one of our Clinical Payment and		
	Adhesiolysis Sessions; 1 Day	Coding Policy (CPCP).		
2287	Decompression Procedure, Percutaneous, Of Nucleus Pulposus Of Intervertebral	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Disc, Any Method Utilizing Needle Based Technique To Remove Disc Material	Not subject to pre-service review. Check EIU		
	Under Fluoroscopic Imaging Or Other Form Of Indirect Visualization, With	policy, which is one of our Clinical Payment and		
	Discography And/Or Epidural Injection(S) At The Treated Level(S), When	Coding Policy (CPCP).		
	Performed, Single Or Multiple Levels, Lumbar			
505	Injection, Anesthetic Agent; Sphenopalatine Ganglion	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1555	Percutaneous Implantation Of Neurostimulator Electrode Array; Peripheral Nerve	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
<del>-</del>	(Excludes Sacral Nerve)	Medical Policy Criteria. Submit for Recommended		

64566	Posterior Tibial Neurostimulation, Percutaneous Needle Electrode, Single Treatment, Includes Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	8/1/2011	12/31/2999
		Clinical Review to avoid post-service review.		
4568	Open Implantation Of Cranial Nerve (Eg, Vagus Nerve) Neurostimulator Electrode	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Array And Pulse Generator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4575	Open Implantation Of Neurostimulator Electrode Array; Peripheral Nerve	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	(Excludes Sacral Nerve)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4582	Open Implantation Of Hypoglossal Nerve Neurostimulator Array, Pulse Generator,	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	And Distal Respiratory Sensor Electrode Or Electrode Array	Medical Policy Criteria. Submit for Recommended		
	That Blocal Hoophatory Colloca Elocatous of Elocatous Taray	Clinical Review to avoid post-service review.		
4583	Revision Or Replacement Of Hypoglossal Nerve Neurostimulator Array And Distal	MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
4000	Respiratory Sensor Electrode Or Electrode Array, Including Connection To	Medical Policy Criteria. Submit for Recommended	3/1/2022	12/01/2000
	Existing Pulse Generator			
4584	Removal Of Hypoglossal Nerve Neurostimulator Array, Pulse Generator, And	Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
1584		MP Criteria: Procedure/service reviewed against	5/1/2022	12/31/2999
	Distal Respiratory Sensor Electrode Or Electrode Array	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1590	Insertion Or Replacement Of Peripheral, Sacral, Or Gastric Neurostimulator Pulse	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Generator Or Receiver, Requiring Pocket Creation And Connection Between	Medical Policy Criteria. Submit for Recommended		
	Electrode Array And Pulse Generator Or Receiver	Clinical Review to avoid post-service review.		
596	Insertion Or Replacement Of Percutaneous Electrode Array, Peripheral Nerve,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	With Integrated Neurostimulator, Including Imaging Guidance, When Performed;	Medical Policy Criteria. Submit for Recommended		
	Initial Electrode Array	Clinical Review to avoid post-service review.		
4597	Insertion Or Replacement Of Percutaneous Electrode Array, Peripheral Nerve,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	With Integrated Neurostimulator, Including Imaging Guidance, When Performed;	Medical Policy Criteria. Submit for Recommended		
	Each Additional Electrode Array (List Separately In Addition To Code For Primary	Clinical Review to avoid post-service review.		
	Procedure)	Chillied Review to avoid post service review.		
4598	Revision Or Removal Of Neurostimulator Electrode Array, Peripheral Nerve, With	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
1000	Integrated Neurostimulator	Medical Policy Criteria. Submit for Recommended	17 172024	12/01/2000
	integrated recursification	Clinical Review to avoid post-service review.		
4615	Chemodenervation Of Muscle(S); Muscle(S) Innervated By Facial, Trigeminal,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
+013			1/1/2013	12/31/2999
	Cervical Spinal And Accessory Nerves, Bilateral (Eg, For Chronic Migraine)	Medical Policy Criteria. Submit for Recommended		
1001		Clinical Review to avoid post-service review.	01110000	40/04/0000
4624	Destruction By Neurolytic Agent, Genicular Nerve Branches Including Imaging	MP Criteria: Procedure/service reviewed against	2/1/2023	12/31/2999
	Guidance, When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1628	Thermal Destruction Of Intraosseous Basivertebral Nerve, Including All Imaging	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	Guidance; First 2 Vertebral Bodies, Lumbar Or Sacral	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
629	Thermal Destruction Of Intraosseous Basivertebral Nerve, Including All Imaging	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	Guidance; Each Additional Vertebral Body, Lumbar Or Sacral (List Separately In	Not subject to pre-service review. Check EIU		
	Addition To Code For Primary Procedure)	policy, which is one of our Clinical Payment and		
	radial to code to trilliary troodalo	Coding Policy (CPCP).		
1640	Destruction By Neurolytic Agent; Other Peripheral Nerve Or Branch	MP Criteria: Procedure/service reviewed against	4/15/2021	12/31/2999
TU-TU	Destruction by Neurolytic Agent, Other Feripheral Nerve Of Brailon	Medical Policy Criteria. Submit for Recommended	7/13/2021	12/3/1/2333
		Clinical Review to avoid post-service review.		

64650	Chemodenervation Of Eccrine Glands; Both Axillae	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64653	Chemodenervation Of Eccrine Glands; Other Area(S) (Eg, Scalp, Face, Neck), Pel	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Day	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64802	Sympathectomy, Cervical	MP Criteria: Procedure/service reviewed against	12/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64804	Sympathectomy, Cervicothoracic	MP Criteria: Procedure/service reviewed against	12/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64809	Sympathectomy, Thoracolumbar	MP Criteria: Procedure/service reviewed against	12/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64818	Sympathectomy, Lumbar	MP Criteria: Procedure/service reviewed against	11/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64820	Sympathectomy; Digital Arteries, Each Digit	MP Criteria: Procedure/service reviewed against	12/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64823	Sympathectomy; Superficial Palmar Arch	MP Criteria: Procedure/service reviewed against	12/15/2015	12/31/2999
0.020	o y pauliosion, y capolineia. i alinia. i ilion	Medical Policy Criteria. Submit for Recommended	12/10/2010	12/01/2000
		Clinical Review to avoid post-service review.		
65710	Keratoplasty (Corneal Transplant); Anterior Lamellar	MP Criteria: Procedure/service reviewed against	7/15/2008	12/31/2999
007.10	Troratoplasty (Combai Transplanty, Thionor Earnonal	Medical Policy Criteria. Submit for Recommended	1710/2000	12/01/2000
		Clinical Review to avoid post-service review.		
65730	Keratoplasty (Corneal Transplant); Penetrating (Except In Aphakia Or	MP Criteria: Procedure/service reviewed against	7/15/2008	12/31/2999
00100	Pseudophakia)	Medical Policy Criteria. Submit for Recommended	17 10/2000	12/01/2000
	1 ocudopridicia)	Clinical Review to avoid post-service review.		
65750	Keratoplasty (Corneal Transplant); Penetrating (In Aphakia)	MP Criteria: Procedure/service reviewed against	7/15/2008	12/31/2999
00100	Trotatoplasty (comodi franoplanty, r chotrating (in riphanta)	Medical Policy Criteria. Submit for Recommended	1710/2000	12/01/2000
		Clinical Review to avoid post-service review.		
65755	Keratoplasty (Corneal Transplant); Penetrating (In Pseudophakia)	MP Criteria: Procedure/service reviewed against	7/15/2008	12/31/2999
33733	Theratoplasty (combai transplant), i enetrating (in i seddophana)	Medical Policy Criteria. Submit for Recommended	1713/2000	12/01/2000
		Clinical Review to avoid post-service review.		
65756	Keratoplasty (Corneal Transplant); Endothelial	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
03730	Relatoplasty (Corneal Transplant), Endothelial	Medical Policy Criteria. Submit for Recommended	1/1/2009	12/3/1/2999
		1		
65757	Backbench Preparation Of Corneal Endothelial Allograft Prior To Transplantation	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
03/3/	(List Separately In Addition To Code For Primary Procedure)	_	1/1/2013	12/3/1/2999
	(List Separately in Addition to Code For Primary Procedure)	Medical Policy Criteria. Submit for Recommended	1	
65760	Keratomileusis	Clinical Review to avoid post-service review.  Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
03/60	relatornileusis	•	1/1/2021	12/31/2999
05705	V a mada mila a lui a	the Plan. Not subject to pre-service review.	4/4/0004	40/04/0000
65765	Keratophakia	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
05707		the Plan. Not subject to pre-service review.	4/45/0000	40/04/0000
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		

65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65771	Radial Keratotomy	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
65772	Corneal Relaxing Incision For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65775	Corneal Wedge Resection For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65778	Placement Of Amniotic Membrane On The Ocular Surface; Without Sutures	MP Criteria: Procedure/service reviewed against	7/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65785	Implantation Of Intrastromal Corneal Ring Segments	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
1		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66174	Transluminal Dilation Of Aqueous Outflow Canal (Eg, Canaloplasty); Without	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
	Retention Of Device Or Stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66175	Transluminal Dilation Of Aqueous Outflow Canal (Eg, Canaloplasty); With	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
	Retention Of Device Or Stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66179	Aqueous Shunt To Extraocular Equatorial Plate Reservoir, External Approach;	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	Without Graft	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66180	Aqueous Shunt To Extraocular Equatorial Plate Reservoir, External Approach;	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
	With Graft	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66183	Insertion Of Anterior Segment Aqueous Drainage Device, Without Extraocular	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Reservoir, External Approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66184	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; Without	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
	Graft	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66185	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; With Graft	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66989		MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
	Stage Procedure), Manual Or Mechanical Technique (Eg, Irrigation And Aspiration	Medical Policy Criteria. Submit for Recommended		
	Or Phacoemulsification), Complex, Requiring Devices Or Techniques Not	Clinical Review to avoid post-service review.		
	Generally Used In Routine Cataract Surgery (Eg, Iris Expansion Device, Suture			
	Support For Intraocular Lens, Or Primary Posterior Capsulorrhexis) Or Performed			
	On Patients In The Amblyogenic Developmental Stage; With Insertion Of			
	Intraocular (Eg, Trabecular Meshwork, Supraciliary, Suprachoroidal) Anterior			
	Segment Aqueous Drainage Device, Without Extraocular Reservoir, Internal			
	Approach, One Or More			

66991	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1	MP Criteria: Procedure/service reviewed against	3/15/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Or Phacoemulsification); With Insertion Of Intraocular (Eg, Trabecular Meshwork,	Clinical Review to avoid post-service review.		
	Supraciliary, Suprachoroidal) Anterior Segment Aqueous Drainage Device,			
7007	Without Extraocular Reservoir, Internal Approach, One Or More	NAD Ocitaria - Duran dano / anni anno di anni dano da anni ant	0/45/0044	40/04/0000
7027	Implantation Of Intravitreal Drug Delivery System (Eg, Ganciclovir Implant),	MP Criteria: Procedure/service reviewed against	6/15/2011	12/31/2999
	Includes Concomitant Removal Of Vitreous	Medical Policy Criteria. Submit for Recommended		
77000	Letter iterative of height of A. Dhamas and a sign A worth (O account a Brown about)	Clinical Review to avoid post-service review.	7/15/2007	40/04/0000
67028	Intravitreal Injection Of A Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
67221	Destruction Of Leadined Lesion Of Chansid (For Chansidal Newscalabination)	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
7221	Destruction Of Localized Lesion Of Choroid (Eg, Choroidal Neovascularization);	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Photodynamic Therapy (Includes Intravenous Infusion)	Medical Policy Criteria. Submit for Recommended		
7005		Clinical Review to avoid post-service review.	4/4/4050	10/04/0000
67225	Destruction Of Localized Lesion Of Choroid (Eg, Choroidal Neovascularization);	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Photodynamic Therapy, Second Eye, At Single Session (List Separately In	Medical Policy Criteria. Submit for Recommended	1	
7510	Addition To Code For Primary Eye Treatment)	Clinical Review to avoid post-service review.	0/45/0004	40/04/0000
67516	Suprachoroidal Space Injection Of Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
7901	Repair Of Blepharoptosis; Frontalis Muscle Technique With Suture Or Other	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Material (Eg, Banked Fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7902	Repair Of Blepharoptosis; Frontalis Muscle Technique With Autologous Fascial	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Sling (Includes Obtaining Fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7903	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement, Internal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67904	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement, External	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
67906		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Obtaining Fascia)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7908	Repair Of Blepharoptosis; Conjunctivo-Tarso-Muller'S Muscle-Levator Resection	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	(Eg, Fasanella-Servat Type)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9090	Ear Piercing	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9300	Otoplasty, Protruding Ear, With Or Without Size Reduction	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	
9676	Tympanic Neurectomy	MP Criteria: Procedure/service reviewed against	11/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9705	Nasopharyngoscopy, Surgical, With Dilation Of Eustachian Tube (le, Balloon	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	Dilation); Unilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

69706	Nasopharyngoscopy, Surgical, With Dilation Of Eustachian Tube (Ie, Balloon Dilation); Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
69716	Implantation, Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Within The Mastoid And/Or Resulting In Removal Of Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2022	12/31/2999
69719	Replacement (Including Removal Of Existing Device), Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Within The Mastoid And/Or Involving A Bony Defect Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2022	12/31/2999
69728	Removal, Entire Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
69729	Implantation, Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside Of The Mastoid And Resulting In Removal Of Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
69730	Replacement (Including Removal Of Existing Device), Osseointegrated Implant, Skull; With Magnetic Transcutaneous Attachment To External Speech Processor, Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
75580	Noninvasive Estimate Of Coronary Fractional Flow Reserve (Ffr) Derived From Augmentative Software Analysis Of The Data Set From A Coronary Computed Tomography Angiography, With Interpretation And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
75894	Transcatheter Therapy, Embolization, Any Method, Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2008	12/31/2999
75956	Endovascular Repair Of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, Dissection, Penetrating Ulcer, Intramural Hematoma, Or Traumatic Disruption); Involving Coverage Of Left Subclavian Artery Origin, Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S), If Required, To Level Of Celiac Artery Origin, Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
75957	Endovascular Repair Of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, Dissection, Penetrating Ulcer, Intramural Hematoma, Or Traumatic Disruption); Not Involving Coverage Of Left Subclavian Artery Origin, Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S), If Required, To Level Of Celiac Artery Origin, Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
75958	Placement Of Proximal Extension Prosthesis For Endovascular Repair Of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, Dissection, Penetrating Ulcer, Intramural Hematoma, Or Traumatic Disruption), Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
75959	Placement Of Distal Extension Prosthesis(S) (Delayed) After Endovascular Repair Of Descending Thoracic Aorta, As Needed, To Level Of Celiac Origin, Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
76120	Cineradiography/Videoradiography, Except Where Specifically Included	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2007	12/31/2999

76125	Cineradiography/Videoradiography To Complement Routine Examination (List	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
10120		Medical Policy Criteria. Submit for Recommended	2/13/2007	12/01/2000
	Soparatery in Addition to Gode to it finially trocedure/	Clinical Review to avoid post-service review.		
76497	Unlisted Computed Tomography Procedure (Eg, Diagnostic, Interventional)	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
0-107	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended	7/1/2021	12/01/2000
		Clinical Review to avoid post-service review.		
76498	Unlisted Magnetic Resonance Procedure (Eg, Diagnostic, Interventional)	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
0.00	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended	17 172021	12/01/2000
		Clinical Review to avoid post-service review.		
76940	Ultrasound Guidance For, And Monitoring Of, Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	.2,0.,2000
		Clinical Review to avoid post-service review.		
76948	Ultrasonic Guidance For Aspiration Of Ova, Imaging Supervision And	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	the Plan. Not subject to pre-service review.		
77013		MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
77299		MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
77399		MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
77499	Unlisted Procedure, Therapeutic Radiology Treatment Management	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
77799	Unlisted Procedure, Clinical Brachytherapy	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
	• • • • • • • • • • • • • • • • • • • •	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
78434	Absolute Quantitation Of Myocardial Blood Flow (Aqmbf), Positron Emission	MP Criteria: Procedure/service reviewed against	9/15/2020	12/31/2999
	Tomography (Pet), Rest And Pharmacologic Stress (List Separately In Addition To			
		Clinical Review to avoid post-service review.		
79445		MP Criteria: Procedure/service reviewed against	2/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
81161	Dmd (Dystrophin) (Eg, Duchenne/Becker Muscular Dystrophy) Deletion Analysis,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	And Duplication Analysis, If Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31206	Bcr/Abl1 (T(9;22)) (Eg, Chronic Myelogenous Leukemia) Translocation Analysis;	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
81207	Bcr/Abl1 (T(9;22)) (Eg, Chronic Myelogenous Leukemia) Translocation Analysis;	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
81241		MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
81243	Fmr1 (Fragile X Messenger Ribonucleoprotein 1) (Eg, Fragile X Syndrome, X-	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
	(Eg, Expanded) Alleles	Clinical Review to avoid post-service review.		1

81420	Fetal Chromosomal Aneuploidy (Eg, Trisomy 21, Monosomy X) Genomic	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
020	Sequence Analysis Panel, Circulating Cell-Free Fetal Dna In Maternal Blood, Must		., ., _ 0 . 0	12/01/2000
	Include Analysis Of Chromosomes 13, 18, And 21	Clinical Review to avoid post-service review.		
81490	Autoimmune (Rheumatoid Arthritis), Analysis Of 12 Biomarkers Using	MP Criteria: Procedure/service reviewed against	12/1/2019	12/31/2999
	Immunoassays, Utilizing Serum, Prognostic Algorithm Reported As A Disease	Medical Policy Criteria. Submit for Recommended		
	Activity Score	Clinical Review to avoid post-service review.		
81503		MP Criteria: Procedure/service reviewed against	4/10/2018	12/31/2999
	A1, Beta-2 Microglobulin, Transferrin, And Pre-Albumin), Utilizing Serum,	Medical Policy Criteria. Submit for Recommended		
	Algorithm Reported As A Risk Score	Clinical Review to avoid post-service review.		
81507	Fetal Aneuploidy (Trisomy 21, 18, And 13) Dna Sequence Analysis Of Selected	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		12.5
	Trisomy	Clinical Review to avoid post-service review.		
81535	Oncology (Gynecologic), Live Tumor Cell Culture And Chemotherapeutic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
01000		Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
İ	Drug Response Score; First Single Drug Or Drug Combination	Clinical Review to avoid post-service review.		
81536	Oncology (Gynecologic), Live Tumor Cell Culture And Chemotherapeutic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Response By Dapi Stain And Morphology, Predictive Algorithm Reported As A	Medical Policy Criteria. Submit for Recommended	5, 1,2020	12/01/2000
I	Drug Response Score; Each Additional Single Drug Or Drug Combination (List	Clinical Review to avoid post-service review.		
	Separately In Addition To Code For Primary Procedure)	Cililical Neview to avoid post-service review.		
81538	Oncology (Lung), Mass Spectrometric 8-Protein Signature, Including Amyloid A,	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
0.000		Medical Policy Criteria. Submit for Recommended	10/0/2010	12/01/2000
	Poor Overall Survival	Clinical Review to avoid post-service review.		
81539	Oncology (High-Grade Prostate Cancer), Biochemical Assay Of Four Proteins	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
01000	7	Medical Policy Criteria. Submit for Recommended	1/1/2017	12/01/2000
	Or Serum, Prognostic Algorithm Reported As A Probability Score	Clinical Review to avoid post-service review.		
81599	Unlisted Multianalyte Assay With Algorithmic Analysis	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
01000	Offiliated Miditaliaryte Assay With Algorithmic Arialysis	Medical Policy Criteria. Submit for Recommended	10/3/2010	12/3 1/2333
		Clinical Review to avoid post-service review.		
82523	Collagen Cross Links, Any Method	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
02323		Not subject to pre-service review. Check EIU	12/13/2014	12/3 1/2999
		policy, which is one of our Clinical Payment and		
82777	Galectin-3	Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
02111	Galectii-3	Medical Policy Criteria. Submit for Recommended	9/1/2020	12/3 1/2999
		,		
83006	Growth Stimulation Expressed Gene 2 (St2, Interleukin 1 Receptor Like-1)	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
63000	Growth Stiffulation Expressed Gene 2 (St2, Interleukin 1 Receptor Like-1)	· ·	9/1/2020	12/3 1/2999
		Medical Policy Criteria. Submit for Recommended		
83695	Lipoprotein (A)	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan.	10/15/0014	12/31/2999
83095	Lipoprotein (A)		12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
00000	1:	Coding Policy (CPCP).	40/45/0044	10/01/0000
83698		EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
83701	Lipoprotein, Blood; High Resolution Fractionation And Quantitation Of Lipoproteins		1/15/2015	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

83704	Lipoprotein, Blood; Quantitation Of Lipoprotein Particle Number(S) (Eg, By Nuclear	EIU: Procedure/service not reimbursed by the Plan.	1/15/2015	12/31/2999
	Magnetic Resonance Spectroscopy), Includes Lipoprotein Particle Subclass(Es),	Not subject to pre-service review. Check EIU		
	When Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
83722	Lipoprotein, Direct Measurement; Small Dense Ldl Cholesterol	EIU: Procedure/service not reimbursed by the Plan.	1/1/2019	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
83937	Osteocalcin (Bone G1A Protein)	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
83987	Ph; Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
84112	Evaluation Of Cervicovaginal Fluid For Specific Amniotic Fluid Protein(S) (Eg,	EIU: Procedure/service not reimbursed by the Plan.	8/15/2015	12/31/2999
	Placental Alpha Microglobulin-1 [Pamg-1], Placental Protein 12 [Pp12], Alpha-	Not subject to pre-service review. Check EIU		
	Fetoprotein), Qualitative, Each Specimen	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
84431	Thromboxane Metabolite(S), Including Thromboxane If Performed, Urine	- · · · · · · · · · · · · · · · · · · ·	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
84999	Unlisted Chemistry Procedure	MP Criteria: Procedure/service reviewed against	10/3/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
86001	Allergen Specific Igg Quantitative Or Semiquantitative, Each Allergen	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).	0/4/0000	40/04/0000
86328	Immunoassay For Infectious Agent Antibody(les), Qualitative Or Semiquantitative,	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	Single-Step Method (Eg, Reagent Strip); Severe Acute Respiratory Syndrome	Not subject to pre-service review. Check EIU		
	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	policy, which is one of our Clinical Payment and		
86343	Leukocyte Histamine Release Test (Lhr)	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	10/1/2020	12/31/2999
86343	Leukocyte nistamine Release Test (Lnir)	Not subject to pre-service review. Check EIU	12/1/2020	12/31/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
86352	Cellular Function Assay Involving Stimulation (Eg, Mitogen Or Antigen) And	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
00002	Detection Of Biomarker (Eg, Atp)	Medical Policy Criteria. Submit for Recommended	1/ 1/2012	12/3/1/2333
	Detection of biomarker (Eg, Atp)	Clinical Review to avoid post-service review.		
86353	Lymphocyte Transformation, Mitogen (Phytomitogen) Or Antigen Induced	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
00000	Blastogenesis	Medical Policy Criteria. Submit for Recommended	17172001	12/3/1/2333
	Diastoyenesis	Clinical Review to avoid post-service review.		
86408	Neutralizing Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	Cov-2) (Coronavirus Disease [Covid-19]); Screen	Not subject to pre-service review. Check EIU	0/1/2020	12/3/1/2333
	(COIOHAVIIUS DISCASC [COVIU-18]), SCIECH	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
		TOURING FULLY (UFUF).		

86409	Neutralizing Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	Cov-2) (Coronavirus Disease [Covid-19]); Titer	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
6413	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	Disease [Covid-19]) Antibody, Quantitative	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
6769	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2)	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	(Coronavirus Disease [Covid-19])	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
6910	Blood Typing, For Paternity Testing, Per Individual; Abo, Rh And Mn	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
6950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed against	4/1/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
37505	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal	MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	Pathogen (Eg, Clostridium Difficile, E. Coli, Salmonella, Shigella, Norovirus,	Medical Policy Criteria. Submit for Recommended		
	Giardia), Includes Multiplex Reverse Transcription, When Performed, And	Clinical Review to avoid post-service review.		
	Multiplex Amplified Probe Technique, Multiple Types Or Subtypes, 3-5 Targets			
7506	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal	MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	Pathogen (Eg, Clostridium Difficile, E. Coli, Salmonella, Shigella, Norovirus,	Medical Policy Criteria. Submit for Recommended		
	Giardia), Includes Multiplex Reverse Transcription, When Performed, And	Clinical Review to avoid post-service review.		
	Multiplex Amplified Probe Technique, Multiple Types Or Subtypes, 6-11 Targets			
37507	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal	MP Criteria: Procedure/service reviewed against	3/15/2020	12/31/2999
	Pathogen (Eg, Clostridium Difficile, E. Coli, Salmonella, Shigella, Norovirus,	Medical Policy Criteria. Submit for Recommended		
	Giardia), Includes Multiplex Reverse Transcription, When Performed, And	Clinical Review to avoid post-service review.		
	Multiplex Amplified Probe Technique, Multiple Types Or Subtypes, 12-25 Targets	· ·		
88375	Optical Endomicroscopic Image(S), Interpretation And Report, Real-Time Or	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Referred, Each Endoscopic Session	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
9250	Culture Of Oocyte(S)/Embryo(S), Less Than 4 Days;	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9251	Culture Of Oocyte(S)/Embryo(S), Less Than 4 Days; With Co-Culture Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Oocyte(S)/Embryos	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9253	Assisted Embryo Hatching, Microtechniques (Any Method)	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9254	Oocyte Identification From Follicular Fluid	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9255	Preparation Of Embryo For Transfer (Any Method)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9257	Sperm Identification From Aspiration (Other Than Seminal Fluid)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39258	Cryopreservation; Embryo(S)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

89259	Cryopreservation; Sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
89260	Sperm Isolation; Simple Prep (Eg, Sperm Wash And Swim-Up) For Insemination	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
00200	Or Diagnosis With Semen Analysis	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
39261	Sperm Isolation; Complex Prep (Eg, Percoll Gradient, Albumin Gradient) For	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
33201	Insemination Or Diagnosis With Semen Analysis	the Plan. Not subject to pre-service review.	1/1/1330	12/01/2000
39264	Sperm Identification From Testis Tissue, Fresh Or Cryopreserved	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
09204	Speriff Identification From Festis Fissue, Fresh of Gryopieserved	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
39268	Insemination Of Oocytes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
30200	modification of coopies	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
89272	Extended Culture Of Oocyte(S)/Embryo(S), 4-7 Days	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
89280	Assisted Oocyte Fertilization, Microtechnique; Less Than Or Equal To 10 Oocytes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
89281	Assisted Oocyte Fertilization, Microtechnique; Greater Than 10 Oocytes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39290	Biopsy, Oocyte Polar Body Or Embryo Blastomere, Microtechnique (For Pre-	MP Criteria: Procedure/service reviewed against	3/1/2012	12/31/2999
	Implantation Genetic Diagnosis); Less Than Or Equal To 5 Embryos	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
39291	Biopsy, Oocyte Polar Body Or Embryo Blastomere, Microtechnique (For Pre-	MP Criteria: Procedure/service reviewed against	3/1/2012	12/31/2999
	Implantation Genetic Diagnosis); Greater Than 5 Embryos	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
39325	Sperm Antibodies	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39329	Sperm Evaluation; Hamster Penetration Test	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1.2.0
89330	Sperm Evaluation; Cervical Mucus Penetration Test, With Or Without Spinnbarkeit	Non Covered: Procedure/service not covered by	11/1/2015	12/31/2999
	Test	the Plan. Not subject to pre-service review.	1	1.2.0
89331	Sperm Evaluation, For Retrograde Ejaculation, Urine (Sperm Concentration,	Non Covered: Procedure/service not covered by	11/1/2015	12/31/2999
	Motility, And Morphology, As Indicated)	the Plan. Not subject to pre-service review.		
39335	Cryopreservation, Reproductive Tissue, Testicular	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
89337	Cryopreservation, Mature Oocyte(S)	Non Covered: Procedure/service not covered by	1/1/2019	12/31/2999
		the Plan. Not subject to pre-service review.		
89342	Storage (Per Year); Embryo(S)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39343	Storage (Per Year); Sperm/Semen	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
89344	Storage (Per Year); Reproductive Tissue, Testicular/Ovarian	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39346	Storage (Per Year); Oocyte(S)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39352	Thawing Of Cryopreserved; Embryo(S)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39353	Thawing Of Cryopreserved; Sperm/Semen, Each Aliquot	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
89354	Thawing Of Cryopreserved; Reproductive Tissue, Testicular/Ovarian	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39356	Thawing Of Cryopreserved; Oocytes, Each Aliquot	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

90378	Respiratory Syncytial Virus, Monoclonal Antibody, Recombinant, For Intramuscular Use, 50 Mg, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2016	12/31/2999
90584	Dengue Vaccine, Quadrivalent, Live, 2 Dose Schedule, For Subcutaneous Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2022	12/31/2999
90624	Meningococcal Pentavalent Vaccine, Men B-4C Recombinant Proteins And Outer Membrane Vesicle And Conjugated Men A, C, W, Y-Diphtheria Toxoid Carrier, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	10/1/2024	12/31/2999
90626	Tick-Borne Encephalitis Virus Vaccine, Inactivated; 0.25 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2021	12/31/2999
90627	Tick-Borne Encephalitis Virus Vaccine, Inactivated; 0.5 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2021	12/31/2999
90637	Influenza Virus Vaccine, Quadrivalent (Qirv), Mrna; 30 Mcg/0.5 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2024	12/31/2999
90638	Influenza Virus Vaccine, Quadrivalent (Qirv), Mrna; 60 Mcg/0.5 Ml Dosage, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2024	12/31/2999
90664	Influenza Virus Vaccine, Live (Laiv), Pandemic Formulation, For Intranasal Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
90666	Influenza Virus Vaccine (liv), Pandemic Formulation, Split Virus, Preservative Free, For Intramuscular Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
90667	Influenza Virus Vaccine (liv), Pandemic Formulation, Split Virus, Adjuvanted, For Intramuscular Use	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
90759	Hepatitis B Vaccine (Hepb), 3-Antigen (S, Pre-S1, Pre-S2), 10 Mcg Dosage, 3  Dose Schedule, For Intramuscular Use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2022	12/31/2999
90867	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Initial, Including Cortical Mapping, Motor Threshold Determination, Delivery And Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90868	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Delivery And Management, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90869	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Motor Threshold Re-Determination With Delivery And Management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90875	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient), With Psychotherapy (Eg, Insight Oriented, Behavior Modifying Or Supportive Psychotherapy); 30 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90876	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient), With Psychotherapy (Eg, Insight Oriented, Behavior Modifying Or Supportive Psychotherapy); 45 Minutes		9/24/2012	12/31/2999
90885	Psychiatric Evaluation Of Hospital Records, Other Psychiatric Reports,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
90889	Preparation Of Report Of Patient'S Psychiatric Status, History, Treatment, Or Progress (Other Than For Legal Or Consultative Purposes) For Other Individuals, Agencies, Or Insurance Carriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999

90901	Biofeedback Training By Any Modality	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
0912	Biofeedback Training, Perineal Muscles, Anorectal Or Urethral Sphincter, Including	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	Emg And/Or Manometry, When Performed; Initial 15 Minutes Of One-On-One	Medical Policy Criteria. Submit for Recommended		
	Physician Or Other Qualified Health Care Professional Contact With The Patient	Clinical Review to avoid post-service review.		
90913	Biofeedback Training, Perineal Muscles, Anorectal Or Urethral Sphincter, Including	<u> </u>	4/1/2021	12/31/2999
	Emg And/Or Manometry, When Performed; Each Additional 15 Minutes Of One-	Medical Policy Criteria. Submit for Recommended		
	On-One Physician Or Other Qualified Health Care Professional Contact With The	Clinical Review to avoid post-service review.		
	Patient (List Separately In Addition To Code For Primary Procedure)			
91034	Esophagus, Gastroesophageal Reflux Test; With Nasal Catheter Ph Electrode(S)	MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	Placement, Recording, Analysis And Interpretation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
91035	Esophagus, Gastroesophageal Reflux Test; With Mucosal Attached Telemetry Ph	MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	Electrode Placement, Recording, Analysis And Interpretation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
91037	Esophageal Function Test, Gastroesophageal Reflux Test With Nasal Catheter	MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	Intraluminal Impedance Electrode(S) Placement, Recording, Analysis And	Medical Policy Criteria. Submit for Recommended		
	Interpretation;	Clinical Review to avoid post-service review.		
91038	Esophageal Function Test, Gastroesophageal Reflux Test With Nasal Catheter	MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	Intraluminal Impedance Electrode(S) Placement, Recording, Analysis And	Medical Policy Criteria. Submit for Recommended		
	Interpretation; Prolonged (Greater Than 1 Hour, Up To 24 Hours)	Clinical Review to avoid post-service review.		
91065	Breath Hydrogen Or Methane Test (Eg, For Detection Of Lactase Deficiency,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Fructose Intolerance, Bacterial Overgrowth, Or Oro-Cecal Gastrointestinal Transit)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
91110	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Esophagus	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	Through Ileum, With Interpretation And Report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
91111	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Esophagus	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	With Interpretation And Report	Not subject to pre-service review. Check EIU		1.2.0
	The many canon, and report	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
91112	Gastrointestinal Transit And Pressure Measurement, Stomach Through Colon,	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
,,,, <u>,</u>	Wireless Capsule, With Interpretation And Report	Not subject to pre-service review. Check EIU	0/1/2020	12/01/2000
	TVIII Close Oupoulo, VVIII Interpretation / Tital Neport	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
91113	Gastrointestinal Tract Imaging, Intraluminal (Eg, Capsule Endoscopy), Colon, With	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
71110	Interpretation And Report	Not subject to pre-service review. Check EIU	17 172020	12/01/2000
	Interpretation And Report	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
91117	Colon Motility (Manometric) Study, Minimum 6 Hours Continuous Recording	MP Criteria: Procedure/service reviewed against	12/1/2020	12/31/2999
71111	(Including Provocation Tests, Eg, Meal, Intracolonic Balloon Distension,	Medical Policy Criteria. Submit for Recommended	12/1/2020	1210112333
11122	Pharmacologic Agents, If Performed), With Interpretation And Report	Clinical Review to avoid post-service review.	12/15/2014	12/31/2999
91132	Electrogastrography, Diagnostic, Transcutaneous;	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

91133	Electrogastrography, Diagnostic, Transcutaneous; With Provocative Testing	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
2065	Orthoptic Training; Performed By A Physician Or Other Qualified Health Care	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	Professional	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
92066	Orthoptic Training; Under Supervision Of A Physician Or Other Qualified Health	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
	Care Professional	Medical Policy Criteria. Submit for Recommended		
20100		Clinical Review to avoid post-service review.	0/4/0000	10/01/0000
92132	Scanning Computerized Ophthalmic Diagnostic Imaging, Anterior Segment, With	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	Interpretation And Report, Unilateral Or Bilateral	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
92145	Corneal Hysteresis Determination, By Air Impulse Stimulation, Unilateral Or	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
12 143	Bilateral, With Interpretation And Report	Not subject to pre-service review. Check EIU	12/1/2020	12/31/2999
	Bilateral, With Interpretation And Report	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
92273	Electroretinography (Erg), With Interpretation And Report; Full Field (Ie, Fferg,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	Flash Erg, Ganzfeld Erg)	Medical Policy Criteria. Submit for Recommended		, . ,
	3, - 3,	Clinical Review to avoid post-service review.		
92274	Electroretinography (Erg), With Interpretation And Report; Multifocal (Mferg)	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
92512	Nasal Function Studies (Eg, Rhinomanometry)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
00547	Marking Forder I Market Datastic I O Committee With Intermediation And	Coding Policy (CPCP).	E/4 E/0004	40/04/0000
92517	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And Report; Cervical (Cvemp)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU	5/15/2021	12/31/2999
	Report, Cervicai (Cverrip)	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
92518	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
320.0	Report; Ocular (Ovemp)	Not subject to pre-service review. Check EIU	0, 10, 2021	.2,0 .,2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
92519	Vestibular Evoked Myogenic Potential (Vemp) Testing, With Interpretation And	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Report; Cervical (Cvemp) And Ocular (Ovemp)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
92520	Laryngeal Function Studies (le, Aerodynamic Testing And Acoustic Testing)	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
205.40		Clinical Review to avoid post-service review.	10/1/0000	40/04/0000
92548	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot), 6	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Conditions (Ie, Eyes Open, Eyes Closed, Visual Sway, Platform Sway, Eyes	Not subject to pre-service review. Check EIU		
	Closed Platform Sway, Platform And Visual Sway), Including Interpretation And	policy, which is one of our Clinical Payment and		
	Report;	Coding Policy (CPCP).		

92549	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot), 6 Conditions (le, Eyes Open, Eyes Closed, Visual Sway, Platform Sway, Eyes Closed Platform Sway, Platform And Visual Sway), Including Interpretation And	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and	12/1/2020	12/31/2999
92601	Report; With Motor Control Test (Mct) And Adaptation Test (Adt)  Diagnostic Analysis Of Cochlear Implant, Patient Younger Than 7 Years Of Age; With Programming	Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
92602	Diagnostic Analysis Of Cochlear Implant, Patient Younger Than 7 Years Of Age; Subsequent Reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
92603	Diagnostic Analysis Of Cochlear Implant, Age 7 Years Or Older; With Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
92622	Diagnostic Analysis, Programming, And Verification Of An Auditory Osseointegrated Sound Processor, Any Type; First 60 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92623	Diagnostic Analysis, Programming, And Verification Of An Auditory Osseointegrated Sound Processor, Any Type; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92640	Diagnostic Analysis With Programming Of Auditory Brainstem Implant, Per Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2008	12/31/2999
92971	Cardioassist-Method Of Circulatory Assist; External	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2008	12/31/2999
92972	Percutaneous Transluminal Coronary Lithotripsy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
92974	Transcatheter Placement Of Radiation Delivery Device For Subsequent Coronary Intravascular Brachytherapy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2008	12/31/2999
92978	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision, Interpretation And Report; Initial Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/5/2018	12/31/2999
92979	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision, Interpretation And Report; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/5/2018	12/31/2999
93025	Microvolt T-Wave Alternans For Assessment Of Ventricular Arrhythmias	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2014	12/31/2999
93050	Arterial Pressure Waveform Analysis For Assessment Of Central Arterial Pressures, Includes Obtaining Waveform(S), Digitization And Application Of Nonlinear Mathematical Transformations To Determine Central Arterial Pressures And Augmentation Index, With Interpretation And Report, Upper Extremity Artery, Non-Invasive	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System, Including All Interrogation And Programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and	5/15/2024	12/31/2999
		Coding Policy (CPCP).		
93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Nerve Stimulator System	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
93152	Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	During Polysomnography	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
93153	Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System		5/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).	0/4/0000	10/01/0000
93228	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And	Clinical Review to avoid post-service review.		
	Patient Selected Events Transmitted To A Remote Attended Surveillance Center			
	For Up To 30 Days; Review And Interpretation With Report By A Physician Or			
02000	Other Qualified Health Care Professional  External Mobile Cardiovascular Telemetry With Electrocardiographic Recording,	MD Criteria: Dress dure/s amiles reviews de accident	4/4/0000	12/31/2999
93229		MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of	· •		
	Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center	Clinical Review to avoid post-service review.		
	For Up To 30 Days; Technical Support For Connection And Patient Instructions			
	For Use, Attended Surveillance, Analysis And Transmission Of Daily And			
	Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health			
	Care Professional			
93260	Programming Device Evaluation (In Person) With Iterative Adjustment Of The	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
33200	Implantable Device To Test The Function Of The Device And Select Optimal	Medical Policy Criteria. Submit for Recommended	1/ 1/2013	12/01/2000
	Permanent Programmed Values With Analysis, Review And Report By A	Clinical Review to avoid post-service review.		
	Physician Or Other Qualified Health Care Professional; Implantable Subcutaneous			
	Lead Defibrillator System			
93261	Interrogation Device Evaluation (In Person) With Analysis, Review And Report By	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	A Physician Or Other Qualified Health Care Professional, Includes Connection,	Medical Policy Criteria. Submit for Recommended		
	Recording And Disconnection Per Patient Encounter; Implantable Subcutaneous	Clinical Review to avoid post-service review.		
	Lead Defibrillator System			
93264	Remote Monitoring Of A Wireless Pulmonary Artery Pressure Sensor For Up To	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	30 Days, Including At Least Weekly Downloads Of Pulmonary Artery Pressure	Medical Policy Criteria. Submit for Recommended		
	Recordings, Interpretation(S), Trend Analysis, And Report(S) By A Physician Or	Clinical Review to avoid post-service review.		
	Other Qualified Health Care Professional			
93278	Signal-Averaged Electrocardiography (Saecg), With Or Without Ecg	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93356	Myocardial Strain Imaging Using Speckle Tracking-Derived Assessment Of	MP Criteria: Procedure/service reviewed against	7/15/2022	12/31/2999
	Myocardial Mechanics (List Separately In Addition To Codes For	Medical Policy Criteria. Submit for Recommended		
	Echocardiography Imaging)	Clinical Review to avoid post-service review.		

93580	Percutaneous Transcatheter Closure Of Congenital Interatrial Communication (le,	MP Criteria: Procedure/service reviewed against	9/15/2007	12/31/2999
	Fontan Fenestration, Atrial Septal Defect) With Implant	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
3640	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-	MP Criteria: Procedure/service reviewed against	1/15/2009	12/31/2999
	Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of	Medical Policy Criteria. Submit for Recommended		
	Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination) At	Clinical Review to avoid post-service review.		
	Time Of Initial Implantation Or Replacement;			
93641	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-	MP Criteria: Procedure/service reviewed against	1/15/2009	12/31/2999
	Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of	Medical Policy Criteria. Submit for Recommended		
	Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination) At	Clinical Review to avoid post-service review.		
	Time Of Initial Implantation Or Replacement; With Testing Of Single Or Dual			
	Chamber Pacing Cardioverter-Defibrillator Pulse Generator			
93642	Electrophysiologic Evaluation Of Single Or Dual Chamber Transvenous Pacing	MP Criteria: Procedure/service reviewed against	2/1/2009	12/31/2999
	Cardioverter-Defibrillator (Includes Defibrillation Threshold Evaluation, Induction Of	Medical Policy Criteria. Submit for Recommended		
	Arrhythmia, Evaluation Of Sensing And Pacing For Arrhythmia Termination, And	Clinical Review to avoid post-service review.		
	Programming Or Reprogramming Of Sensing Or Therapeutic Parameters)	·		
93644	Electrophysiologic Evaluation Of Subcutaneous Implantable Defibrillator (Includes	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	Defibrillation Threshold Evaluation, Induction Of Arrhythmia, Evaluation Of	Medical Policy Criteria. Submit for Recommended		
	Sensing For Arrhythmia Termination, And Programming Or Reprogramming Of	Clinical Review to avoid post-service review.		
	Sensing Or Therapeutic Parameters)	·		
93660	Evaluation Of Cardiovascular Function With Tilt Table Evaluation, With Continuous	MP Criteria: Procedure/service reviewed against	5/15/2008	12/31/2999
	Ecg Monitoring And Intermittent Blood Pressure Monitoring, With Or Without	Medical Policy Criteria. Submit for Recommended		
	Pharmacological Intervention	Clinical Review to avoid post-service review.		
93701	Bioimpedance-Derived Physiologic Cardiovascular Analysis	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93702	Bioimpedance Spectroscopy (Bis), Extracellular Fluid Analysis For Lymphedema	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Assessment(S)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
93797	Physician Or Other Qualified Health Care Professional Services For Outpatient	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Cardiac Rehabilitation; Without Continuous Ecg Monitoring (Per Session)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93798	Physician Or Other Qualified Health Care Professional Services For Outpatient	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Cardiac Rehabilitation; With Continuous Ecg Monitoring (Per Session)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93886	Transcranial Doppler Study Of The Intracranial Arteries; Complete Study	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93888	Transcranial Doppler Study Of The Intracranial Arteries; Limited Study	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93890	Transcranial Doppler Study Of The Intracranial Arteries; Vasoreactivity Study	MP Criteria: Procedure/service reviewed against	7/1/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

93892	Transcranial Doppler Study Of The Intracranial Arteries; Emboli Detection Without Intravenous Microbubble Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
93893	Transcranial Doppler Study Of The Intracranial Arteries; Emboli Detection With Intravenous Microbubble Injection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
94014	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Includes Reinforced Education, Transmission Of Spirometric Tracing, Data Capture, Analysis Of Transmitted Data, Periodic Recalibration And Review And Interpretation By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
94015	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Recording (Includes Hook-Up, Reinforced Education, Data Transmission, Data Capture, Trend Analysis, And Periodic Recalibration)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
94016	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Review And Interpretation Only By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
94669	Mechanical Chest Wall Oscillation To Facilitate Lung Function, Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
94774	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate, Pattern And Heart Rate Per 30-Day Period Of Time; Includes Monitor Attachment, Download Of Data, Review, Interpretation, And Preparation Of A Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
94775	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate, Pattern And Heart Rate Per 30-Day Period Of Time; Monitor Attachment Only (Includes Hook-Up, Initiation Of Recording And Disconnection)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
94776	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate, Pattern And Heart Rate Per 30-Day Period Of Time; Monitoring, Download Of Information, Receipt Of Transmission(S) And Analyses By Computer Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
94777	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate, Pattern And Heart Rate Per 30-Day Period Of Time; Review, Interpretation And Preparation Of Report Only By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
95060	Ophthalmic Mucous Membrane Tests	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
95065	Direct Nasal Mucous Membrane Test	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
95700	Setup, Patient Education, And Takedown When Performed, Administered In Person By Eeg Technologist, Minimum Of 8 Channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95705	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical Description By Eeg Technologist, 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999

95706	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Description By Eeg Technologist, 2-12 Hours; With Intermittent Monitoring And	Medical Policy Criteria. Submit for Recommended		
	Maintenance	Clinical Review to avoid post-service review.		
5707	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Description By Eeg Technologist, 2-12 Hours; With Continuous, Real-Time	Medical Policy Criteria. Submit for Recommended		
	Monitoring And Maintenance	Clinical Review to avoid post-service review.		
5708	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Description By Eeg Technologist, Each Increment Of 12-26 Hours; Unmonitored	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5709	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Description By Eeg Technologist, Each Increment Of 12-26 Hours; With	Medical Policy Criteria. Submit for Recommended		
	Intermittent Monitoring And Maintenance	Clinical Review to avoid post-service review.		
5710	Electroencephalogram (Eeg), Without Video, Review Of Data, Technical	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Description By Eeg Technologist, Each Increment Of 12-26 Hours; With	Medical Policy Criteria. Submit for Recommended		1-7-1
	Continuous, Real-Time Monitoring And Maintenance	Clinical Review to avoid post-service review.		
5711		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	By Eeg Technologist, 2-12 Hours; Unmonitored	Medical Policy Criteria. Submit for Recommended		1-7-1
		Clinical Review to avoid post-service review.		
5712	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
0.12		Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	by Log Toolhoogist, 2 12 Hours, With Internation Monitoring 7 and Mainton and	Clinical Review to avoid post-service review.		
5713	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
01 10	By Eeg Technologist, 2-12 Hours; With Continuous, Real-Time Monitoring And	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	Maintenance	Clinical Review to avoid post-service review.		
5714		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
0714	By Eeg Technologist, Each Increment Of 12-26 Hours; Unmonitored	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	by Eog Toolinologist, East more month of 12 20 Flours, Offinolinologist	Clinical Review to avoid post-service review.		
5715	Electroencephalogram With Video (Veeg), Review Of Data, Technical Description	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
07 10	By Eeg Technologist, Each Increment Of 12-26 Hours; With Intermittent	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	Monitoring And Maintenance	Clinical Review to avoid post-service review.		
5716		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
57 10	By Eeg Technologist, Each Increment Of 12-26 Hours; With Continuous, Real-	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	Time Monitoring And Maintenance	Clinical Review to avoid post-service review.		
5717		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
57 17	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
	Seizure Detection, Interpretation And Report, 2-12 Hours Of Eeg Recording;	Clinical Review to avoid post-service review.		
	Without Video	Cililical Review to avoid post-service review.		
5718		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
07 10	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
	Video (Veeg)	Chilical Review to avoid post-service review.		
5719		MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
0.10	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	1 1, 1, 2020	12/01/2000
		Clinical Review to avoid post-service review.		
	Eeg Recording, Interpretation And Report After Each 24-Hour Period; Without	Confident Neview to avoid post-service review.		
	Leg Necoluling, interpretation And Report After Each 24-Hour Period, Without			

95720	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
33120	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	1 1/ 1/2020	12/3/1/2888
	Seizure Detection, Each Increment Of Greater Than 12 Hours, Up To 26 Hours Of			
	Eeg Recording, Interpretation And Report After Each 24-Hour Period; With Video	Cillical Neview to avoid post-service review.		
I	(Veed)			
95721	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
00721	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	117172020	12/01/2000
		Clinical Review to avoid post-service review.		
l	Than 36 Hours, Up To 60 Hours Of Eeg Recording, Without Video	Omnour Neview to avoid post service review.		
95722	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
00.22	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended	,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12/01/2000
1	· · · · · · · · · · · · · · · · · · ·	Clinical Review to avoid post-service review.		
	Than 36 Hours, Up To 60 Hours Of Eeg Recording, With Video (Veeg)	Official Neview to avoid post-service review.		
	Than 50 Hours, op 10 00 Hours of Leg Recording, with video (veeg)			
95723	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
-	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	Than 60 Hours, Up To 84 Hours Of Eeg Recording, Without Video	The state of the s		
95724	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	Than 60 Hours, Up To 84 Hours Of Eeg Recording, With Video (Veeg)			
	Than 30 Hours, Sp 10 0 Hours Or 20g House and g, 11 and (100g)			
95725	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater			
	Than 84 Hours Of Eeg Recording, Without Video	i '		
95726	Electroencephalogram (Eeg), Continuous Recording, Physician Or Other Qualified	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	Health Care Professional Review Of Recorded Events, Analysis Of Spike And	Medical Policy Criteria. Submit for Recommended		
	Seizure Detection, Interpretation, And Summary Report, Complete Study; Greater	Clinical Review to avoid post-service review.		
	Than 84 Hours Of Eeg Recording, With Video (Veeg)	i '		
95782	Polysomnography; Younger Than 6 Years, Sleep Staging With 4 Or More	MP Criteria: Procedure/service reviewed against	7/15/2022	12/31/2999
	Additional Parameters Of Sleep, Attended By A Technologist	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95783	Polysomnography; Younger Than 6 Years, Sleep Staging With 4 Or More	MP Criteria: Procedure/service reviewed against	7/15/2022	12/31/2999
	Additional Parameters Of Sleep, With Initiation Of Continuous Positive Airway	Medical Policy Criteria. Submit for Recommended		
	Pressure Therapy Or Bi-Level Ventilation, Attended By A Technologist	Clinical Review to avoid post-service review.	<u> </u>	
95803	Actigraphy Testing, Recording, Analysis, Interpretation, And Report (Minimum Of	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
95805		MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Analysis And Interpretation Of Physiological Measurements Of Sleep During	Medical Policy Criteria. Submit for Recommended		
	Multiple Trials To Assess Sleepiness	Clinical Review to avoid post-service review.		
95807	Sleep Study, Simultaneous Recording Of Ventilation, Respiratory Effort, Ecg Or	MP Criteria: Procedure/service reviewed against	5/15/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
95808	Polysomnography; Any Age, Sleep Staging With 1-3 Additional Parameters Of	MP Criteria: Procedure/service reviewed against	5/15/2022	12/31/2999
	Sleep, Attended By A Technologist	Medical Policy Criteria. Submit for Recommended		
	1 '	Clinical Review to avoid post-service review.		

95810	Polysomnography; Age 6 Years Or Older, Sleep Staging With 4 Or More Additional Parameters Of Sleep, Attended By A Technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	2/15/2022	12/31/2999
95811	Polysomnography; Age 6 Years Or Older, Sleep Staging With 4 Or More Additional Parameters Of Sleep, With Initiation Of Continuous Positive Airway Pressure Therapy Or Bilevel Ventilation, Attended By A Technologist	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2022	12/31/2999
95905	Motor And/Or Sensory Nerve Conduction, Using Preconfigured Electrode Array(S),		9/1/2020	12/31/2999
95919	Quantitative Pupillometry With Physician Or Other Qualified Health Care Professional Interpretation And Report, Unilateral Or Bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
95954	Pharmacological Or Physical Activation Requiring Physician Or Other Qualified Health Care Professional Attendance During Eeg Recording Of Activation Phase (Eg. Thiopental Activation Test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95957		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
95961	Electrodes On Brain Surface, Or Of Depth Electrodes, To Provoke Seizures Or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2015	12/31/2999
95962	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface, Or Of Depth Electrodes, To Provoke Seizures Or	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2015	12/31/2999
95965		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95966	Magnetoencephalography (Meg), Recording And Analysis; For Evoked Magnetic Fields, Single Modality (Eg, Sensory, Motor, Language, Or Visual Cortex Localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95967	Magnetoencephalography (Meg), Recording And Analysis; For Evoked Magnetic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95970	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz], On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop Parameters, And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Brain, Cranial Nerve, Spinal Cord, Peripheral Nerve, Or Sacral Nerve, Neurostimulator Pulse Generator/Transmitter, Without Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

95971	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
95971		_	1/1/1950	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended		
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop			
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Simple Spinal Cord Or Peripheral Nerve (Eg, Sacral			
	Nerve) Neurostimulator Pulse Generator/Transmitter Programming By Physician			
	Or Other Qualified Health Care Professional			
95972	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended		
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop			
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Complex Spinal Cord Or Peripheral Nerve (Eg, Sacral			
	Nerve) Neurostimulator Pulse Generator/Transmitter Programming By Physician			
	Or Other Qualified Health Care Professional			
95976	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended		
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop	·		
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Simple Cranial Nerve Neurostimulator Pulse			
	Generator/Transmitter Programming By Physician Or Other Qualified Health Care			
	Professional			
95977	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended		
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop	'		
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Complex Cranial Nerve Neurostimulator Pulse			
	Generator/Transmitter Programming By Physician Or Other Qualified Health Care			
	Professional			
95981	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	Rate, Pulse Amplitude And Duration, Configuration Of Wave Form, Battery Status,			1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	Electrode Selectability, Output Modulation, Cycling, Impedance And Patient	Clinical Review to avoid post-service review.		
	Measurements) Gastric Neurostimulator Pulse Generator/Transmitter;			
	Subsequent, Without Reprogramming			
95982	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
00002			., ., _	1.270 172000
	Electrode Selectability, Output Modulation, Cycling, Impedance And Patient	Clinical Review to avoid post-service review.		
	Measurements) Gastric Neurostimulator Pulse Generator/Transmitter;	Chillion Review to avoid poor service review.		
	Subsequent, With Reprogramming			
95983	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended	1, 1,2010	12/01/2000
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop	Ominoal Noview to avoid post-service review.		
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Brain Neurostimulator Pulse Generator/Transmitter			
	Programming, First 15 Minutes Face-To-Face Time With Physician Or Other			
	Qualified Health Care Professional			

95984	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	(Eg, Contact Group[S], Interleaving, Amplitude, Pulse Width, Frequency [Hz],	Medical Policy Criteria. Submit for Recommended		
	On/Off Cycling, Burst, Magnet Mode, Dose Lockout, Patient Selectable	Clinical Review to avoid post-service review.		
	Parameters, Responsive Neurostimulation, Detection Algorithms, Closed Loop			
	Parameters, And Passive Parameters) By Physician Or Other Qualified Health			
	Care Professional; With Brain Neurostimulator Pulse Generator/Transmitter			
	Programming, Each Additional 15 Minutes Face-To-Face Time With Physician Or			
	Other Qualified Health Care Professional (List Separately In Addition To Code For			
	Primary Procedure)			
6000	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	Kinematics;	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
6001	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
	Kinematics; With Dynamic Plantar Pressure Measurements During Walking	Medical Policy Criteria. Submit for Recommended		
	, <u>- ,</u>	Clinical Review to avoid post-service review.		
6002	Dynamic Surface Electromyography, During Walking Or Other Functional	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
<b></b>	Activities, 1-12 Muscles	Medical Policy Criteria. Submit for Recommended		12/3 // 2000
	, territor, i iz massios	Clinical Review to avoid post-service review.		
6003	Dynamic Fine Wire Electromyography, During Walking Or Other Functional	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
0000	Activities, 1 Muscle	Medical Policy Criteria. Submit for Recommended	7710/2010	12/01/2000
	Activities, 1 Muscic	Clinical Review to avoid post-service review.		
6004	Review And Interpretation By Physician Or Other Qualified Health Care	MP Criteria: Procedure/service reviewed against	7/15/2010	12/31/2999
3004	Professional Of Comprehensive Computer-Based Motion Analysis, Dynamic	Medical Policy Criteria. Submit for Recommended	7713/2010	12/01/2000
	Plantar Pressure Measurements, Dynamic Surface Electromyography During	Clinical Review to avoid post-service review.		
	Walking Or Other Functional Activities, And Dynamic Fine Wire Electromyography,	Cillical Neview to avoid post-service review.		
	With Written Report			
6547	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
0047	Including Separate Incision(S) And Closure, When Performed; First 60 Minutes	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/01/2000
	(List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
6548	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
0540	Including Separate Incision(S) And Closure, When Performed; Each Additional 30	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
		1		
6567	Minutes (List Separately In Addition To Code For Primary Procedure)  Photodynamic Therapy By External Application Of Light To Destroy Premalignant	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
0007			1/1/1950	12/31/2999
	Lesions Of The Skin And Adjacent Mucosa With Application And	Medical Policy Criteria. Submit for Recommended		
6570	Illumination/Activation Of Photosensitive Drug(S), Per Day	Clinical Review to avoid post-service review.	9/15/2008	12/31/2999
6570	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal	MP Criteria: Procedure/service reviewed against	9/10/2008	12/31/2999
	Tissue Via Activation Of Photosensitive Drug(S); First 30 Minutes (List Separately	Medical Policy Criteria. Submit for Recommended		
	In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of Lung And	Clinical Review to avoid post-service review.		
0574	Gastrointestinal Tract)	lup o '' · · · · · · · · · · · · · · · · ·	0/45/0000	10/04/0000
6571	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal	MP Criteria: Procedure/service reviewed against	9/15/2008	12/31/2999
	Tissue Via Activation Of Photosensitive Drug(S); Each Additional 15 Minutes (List	Medical Policy Criteria. Submit for Recommended		
	Separately In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of	Clinical Review to avoid post-service review.		
	Lung And Gastrointestinal Tract)			
6573	Photodynamic Therapy By External Application Of Light To Destroy Premalignant	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Lesions Of The Skin And Adjacent Mucosa With Application And	Medical Policy Criteria. Submit for Recommended		
	Illumination/Activation Of Photosensitizing Drug(S) Provided By A Physician Or	Clinical Review to avoid post-service review.		
	Other Qualified Health Care Professional, Per Day	· ·		

96574	Debridement Of Premalignant Hyperkeratotic Lesion(S) (le, Targeted Curettage,	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		, .,
	To Destroy Premalignant Lesions Of The Skin And Adjacent Mucosa With	Clinical Review to avoid post-service review.		
	Application And Illumination/Activation Of Photosensitizing Drug(S) Provided By A			
	Physician Or Other Qualified Health Care Professional, Per Day			
96912	Photochemotherapy, Psoralens And Ultraviolet A (Puva)	MP Criteria: Procedure/service reviewed against	8/15/2009	12/31/2999
	· · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96913	Photochemotherapy (Goeckerman And/Or Puva) For Severe Photoresponsive	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	Dermatoses Requiring At Least 4-8 Hours Of Care Under Direct Supervision Of	Medical Policy Criteria. Submit for Recommended		
	The Physician (Includes Application Of Medication And Dressings)	Clinical Review to avoid post-service review.		
96922	Excimer Laser Treatment For Psoriasis; Over 500 Sq Cm	MP Criteria: Procedure/service reviewed against	10/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96931	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Skin; Image Acquisition And Interpretation And Report, First Lesion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96932	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	Skin; Image Acquisition Only, First Lesion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96933	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Skin; Interpretation And Report Only, First Lesion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96934	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Skin; Image Acquisition And Interpretation And Report, Each Additional Lesion	Medical Policy Criteria. Submit for Recommended		
	(List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
96935		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Skin; Image Acquisition Only, Each Additional Lesion (List Separately In Addition	Medical Policy Criteria. Submit for Recommended		
	To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
96936		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Skin; Interpretation And Report Only, Each Additional Lesion (List Separately In	Medical Policy Criteria. Submit for Recommended		
	Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
97012	Application Of A Modality To 1 Or More Areas; Traction, Mechanical	Non Covered: Procedure/service not covered by	5/1/2015	12/31/2999
		the Plan. Not subject to pre-service review.		
97014	Application Of A Modality To 1 Or More Areas; Electrical Stimulation (Unattended)	Non Covered: Procedure/service not covered by	11/14/2012	12/31/2999
		the Plan. Not subject to pre-service review.		
97024	Application Of A Modality To 1 Or More Areas; Diathermy (Eg, Microwave)	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97032	Application Of A Modality To 1 Or More Areas; Electrical Stimulation (Manual),	Non Covered: Procedure/service not covered by	11/14/2012	12/31/2999
	Each 15 Minutes	the Plan. Not subject to pre-service review.		
97037	Application Of A Modality To 1 Or More Areas; Low-Level Laser Therapy (le,	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Nonthermal And Non-Ablative) For Post-Operative Pain Reduction	Medical Policy Criteria. Submit for Recommended		
	The state of the s	Clinical Review to avoid post-service review.		
97124	Therapeutic Procedure, 1 Or More Areas, Each 15 Minutes; Massage, Including	Non Covered: Procedure/service not covered by	1/1/2016	12/31/2999
·- ·		the Plan. Not subject to pre-service review.	., .,2010	.2,01,2000

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97169	Athletic Training Evaluation, Low Complexity, Requiring These Components: A	Non Covered: Procedure/service not covered by	1/1/2017	12/31/2999
	History And Physical Activity Profile With No Comorbidities That Affect Physical	the Plan. Not subject to pre-service review.		
	Activity; An Examination Of Affected Body Area And Other Symptomatic Or			
	Related Systems Addressing 1-2 Elements From Any Of The Following: Body			
	Structures, Physical Activity, And/Or Participation Deficiencies; And Clinical			
	Decision Making Of Low Complexity Using Standardized Patient Assessment			
	Instrument And/Or Measurable Assessment Of Functional Outcome. Typically, 15			
	Minutes Are Spent Face-To-Face With The Patient And/Or Family.			
97170	Athletic Training Evaluation, Moderate Complexity, Requiring These Components:	Non Covered: Procedure/service not covered by	1/1/2017	12/31/2999
	A Medical History And Physical Activity Profile With 1-2 Comorbidities That Affect	the Plan. Not subject to pre-service review.		
	Physical Activity; An Examination Of Affected Body Area And Other Symptomatic			
	Or Related Systems Addressing A Total Of 3 Or More Elements From Any Of The			
	Following: Body Structures, Physical Activity, And/Or Participation Deficiencies;			
	And Clinical Decision Making Of Moderate Complexity Using Standardized Patient			
	Assessment Instrument And/Or Measurable Assessment Of Functional Outcome.			
	Typically, 30 Minutes Are Spent Face-To-Face With The Patient And/Or Family.			
97171	Athletic Training Evaluation, High Complexity, Requiring These Components: A	Non Covered: Procedure/service not covered by	1/1/2017	12/31/2999
	Medical History And Physical Activity Profile, With 3 Or More Comorbidities That	the Plan. Not subject to pre-service review.		
	Affect Physical Activity; A Comprehensive Examination Of Body Systems Using			
	Standardized Tests And Measures Addressing A Total Of 4 Or More Elements			
	From Any Of The Following: Body Structures, Physical Activity, And/Or			
	Participation Deficiencies; Clinical Presentation With Unstable And Unpredictable			
	Characteristics; And Clinical Decision Making Of High Complexity Using			
	Standardized Patient Assessment Instrument And/Or Measurable Assessment Of			
	Functional Outcome. Typically, 45 Minutes Are Spent Face-To-Face With The			
	Patient And/Or Family.			
97172	Re-Evaluation Of Athletic Training Established Plan Of Care Requiring These	Non Covered: Procedure/service not covered by	1/1/2017	12/31/2999
	Components: An Assessment Of Patient'S Current Functional Status When There	the Plan. Not subject to pre-service review.		
	Is A Documented Change, And A Revised Plan Of Care Using A Standardized			
	Patient Assessment Instrument And/Or Measurable Assessment Of Functional			
	Outcome With An Update In Management Options, Goals, And Interventions.			
	Typically, 20 Minutes Are Spent Face-To-Face With The Patient And/Or Family.			
97533	Sensory Integrative Techniques To Enhance Sensory Processing And Promote	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Adaptive Responses To Environmental Demands, Direct (One-On-One) Patient	Medical Policy Criteria. Submit for Recommended		
	Contact, Each 15 Minutes	Clinical Review to avoid post-service review.		
97537	Community/Work Reintegration Training (Eg, Shopping, Transportation, Money	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
	Management, Avocational Activities And/Or Work Environment/Modification	the Plan. Not subject to pre-service review.		
	Analysis, Work Task Analysis, Use Of Assistive Technology Device/Adaptive	, ·		
	Equipment), Direct One-On-One Contact, Each 15 Minutes			
97545	Work Hardening/Conditioning; Initial 2 Hours	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97546	Work Hardening/Conditioning; Each Additional Hour (List Separately In Addition	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	To Code For Primary Procedure)	Medical Policy Criteria. Submit for Recommended	1	
	1.5 5540 For Filling Frooduito,	Clinical Review to avoid post-service review.		
97605	Negative Pressure Wound Therapy (Eg, Vacuum Assisted Drainage Collection),	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Utilizing Durable Medical Equipment (Dme), Including Topical Application(S),	Medical Policy Criteria. Submit for Recommended	.,_,,,,	.2/01/2000
	Wound Assessment, And Instruction(S) For Ongoing Care, Per Session; Total	Clinical Review to avoid post-service review.		
	Wound(S) Surface Area Less Than Or Equal To 50 Square Centimeters	Official Neview to avoid post-service review.		
	Ivvounu(3) Sunace Area Less Than Of Equal 10 30 Square Centimeters		1	

97606	Negative Pressure Wound Therapy (Eg, Vacuum Assisted Drainage Collection),	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Utilizing Durable Medical Equipment (Dme), Including Topical Application(S),	Medical Policy Criteria. Submit for Recommended		
	Wound Assessment, And Instruction(S) For Ongoing Care, Per Session; Total	Clinical Review to avoid post-service review.		
	Wound(S) Surface Area Greater Than 50 Square Centimeters	·		
7607	Negative Pressure Wound Therapy, (Eg, Vacuum Assisted Drainage Collection),	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	Utilizing Disposable, Non-Durable Medical Equipment Including Provision Of	Medical Policy Criteria. Submit for Recommended		
	Exudate Management Collection System, Topical Application(S), Wound	Clinical Review to avoid post-service review.		
	Assessment, And Instructions For Ongoing Care, Per Session; Total Wound(S)	'		
	Surface Area Less Than Or Equal To 50 Square Centimeters			
7608	Negative Pressure Wound Therapy, (Eg, Vacuum Assisted Drainage Collection),	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	Utilizing Disposable, Non-Durable Medical Equipment Including Provision Of	Medical Policy Criteria. Submit for Recommended		
	Exudate Management Collection System, Topical Application(S), Wound	Clinical Review to avoid post-service review.		
	Assessment, And Instructions For Ongoing Care, Per Session; Total Wound(S)	Ciminal Novigin to avoid poor control		
	Surface Area Greater Than 50 Square Centimeters			
7610	Low Frequency, Non-Contact, Non-Thermal Ultrasound, Including Topical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	Application(S), When Performed, Wound Assessment, And Instruction(S) For	Not subject to pre-service review. Check EIU	0, 1, 2020	.2,0.,2000
	Ongoing Care, Per Day	policy, which is one of our Clinical Payment and		
	origoning date, i or buy	Coding Policy (CPCP).		
7810	Acupuncture, 1 Or More Needles; Without Electrical Stimulation, Initial 15 Minutes	Non Covered: Procedure/service not covered by	3/15/2013	12/31/2999
	Of Personal One-On-One Contact With The Patient	the Plan. Not subject to pre-service review.		1
7811	Acupuncture, 1 Or More Needles; Without Electrical Stimulation, Each Additional	Non Covered: Procedure/service not covered by	3/15/2013	12/31/2999
		the Plan. Not subject to pre-service review.		1
	Of Needle(S) (List Separately In Addition To Code For Primary Procedure)	The real rest of the process restaur.		
7813		Non Covered: Procedure/service not covered by	3/15/2013	12/31/2999
	Personal One-On-One Contact With The Patient	the Plan. Not subject to pre-service review.		1
97814	Acupuncture, 1 Or More Needles; With Electrical Stimulation, Each Additional 15	Non Covered: Procedure/service not covered by	3/15/2013	12/31/2999
		the Plan. Not subject to pre-service review.		
	Needle(S) (List Separately In Addition To Code For Primary Procedure)			
98962	Education And Training For Patient Self-Management By A Qualified,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Nonphysician Health Care Professional Using A Standardized Curriculum, Face-	the Plan. Not subject to pre-service review.	, , , , , , ,	1
	To-Face With The Patient (Could Include Caregiver/Family) Each 30 Minutes; 5-8			
	Patients			
99026	Hospital Mandated On Call Service; In-Hospital, Each Hour	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	, , , , , , ,	1
9027	Hospital Mandated On Call Service; Out-Of-Hospital, Each Hour	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	,,	the Plan. Not subject to pre-service review.	, , , , , , ,	1
9071	Educational Supplies, Such As Books, Tapes, And Pamphlets, For The Patient'S	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Education At Cost To Physician Or Other Qualified Health Care Professional	the Plan. Not subject to pre-service review.	, , , , , , ,	
9075	Medical Testimony	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	., .,	, 0 . , _ 0 0 0
9080	Special Reports Such As Insurance Forms, More Than The Information Conveyed	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
•	In The Usual Medical Communications Or Standard Reporting Form	the Plan. Not subject to pre-service review.		12.7.1.
9082	Unusual Travel (Eg, Transportation And Escort Of Patient)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
.0002	onasaa Tarsi (Eg, Tanoportation / Ind Essort Of Fatishing	the Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
9360	Standby Service, Requiring Prolonged Attendance, Each 30 Minutes (Eg,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
.0000	Operative Standby, Standby For Frozen Section, For Cesarean/High Risk Delivery,		1, 1, 1000	12/01/2000
		The Flan. Not subject to pre-service review.		
	For Monitoring Eeg)			

99450	Basic Life And/Or Disability Examination That Includes: Measurement Of Height, Weight, And Blood Pressure; Completion Of A Medical History Following A Life	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
	Insurance Pro Forma; Collection Of Blood Sample And/Or Urinalysis Complying With Chain Of Custody Protocols; And Completion Of Necessary Documentation/Certificates.	,		
99455	Work Related Or Medical Disability Examination By The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis, Assessment Of Capabilities And Stability, And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
99456	Work Related Or Medical Disability Examination By Other Than The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis, Assessment Of Capabilities And Stability, And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
99509	Home Visit For Assistance With Activities Of Daily Living And Personal Care	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
99512	Home Visit For Hemodialysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2008	12/31/2999
0052U	Lipoprotein, Blood, High Resolution Fractionation And Quantitation Of Lipoproteins, Including All Five Major Lipoprotein Classes And Subclasses Of Hdl, Ldl, And Vldl By Vertical Auto Profile Ultracentrifugation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2018	12/31/2999
0054T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure, With Image-Guidance Based On Fluoroscopic Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0055T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure, With Image-Guidance Based On Ct/Mri Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0062U	Autoimmune (Systemic Lupus Erythematosus), Igg And Igm Analysis Of 80 Biomarkers, Utilizing Serum, Algorithm Reported With A Risk Score		12/1/2020	12/31/2999
0063U	Neurology (Autism), 32 Amines By Lc-Ms/Ms, Using Plasma, Algorithm Reported As Metabolic Signature Associated With Autism Spectrum Disorder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0071T	Focused Ultrasound Ablation Of Uterine Leiomyomata, Including Mr Guidance; Total Leiomyomata Volume Less Than 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

0072T	Focused Ultrasound Ablation Of Uterine Leiomyomata, Including Mr Guidance;	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Total Leiomyomata Volume Greater Or Equal To 200 Cc Of Tissue	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
0075T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S), Including Radiologic Supervision And Interpretation, Open Or Percutaneous; Initial Vessel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
0076T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S), Including Radiologic Supervision And Interpretation, Open Or Percutaneous; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
101T	Extracorporeal Shock Wave Involving Musculoskeletal System, Not Otherwise Specified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	11/1/2016	12/31/2999
)102T	Extracorporeal Shock Wave Performed By A Physician, Requiring Anesthesia Other Than Local, And Involving The Lateral Humeral Epicondyle	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0105U	Nephrology (Chronic Kidney Disease), Multiplex Electrochemiluminescent Immunoassay (Eclia) Of Tumor Necrosis Factor Receptor 1A, Receptor Superfamily 2 (Tnfr1, Tnfr2), And Kidney Injury Molecule-1 (Kim-1) Combined With Longitudinal Clinical Data, Including Apol1 Genotype If Available, And Plasma (Isolated Fresh Or Frozen), Algorithm Reported As Probability Score For Rapid Kidney Function Decline (Rkfd)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
0106T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Touch Pressure Stimuli To Assess Large Diameter Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0106U	Gastric Emptying, Serial Collection Of 7 Timed Breath Specimens, Non-Radioisotope Carbon-13 (13C) Spirulina Substrate, Analysis Of Each Specimen By Gas Isotope Ratio Mass Spectrometry, Reported As Rate Of 13Co2 Excretion	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
0107T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Vibration Stimuli To Assess Large Diameter Fiber Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0108T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Cooling Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
)109T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Heat-Pain Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
)110T	Quantitative Sensory Testing (Qst), Testing And Interpretation Per Extremity; Using Other Stimuli To Assess Sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

0175T	Computer-Aided Detection (Cad) (Computer Algorithm Analysis Of Digital Image	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Data For Lesion Detection) With Further Physician Review For Interpretation And	Medical Policy Criteria. Submit for Recommended		
	Report, With Or Without Digitization Of Film Radiographic Images, Chest	Clinical Review to avoid post-service review.		
	Radiograph(S), Performed Remote From Primary Interpretation	·		
)184T	Excision Of Rectal Tumor, Transanal Endoscopic Microsurgical Approach (le,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Tems), Including Muscularis Propria (le, Full Thickness)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0198T	Measurement Of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	With Interpretation And Report	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0200T	Percutaneous Sacral Augmentation (Sacroplasty), Unilateral Injection(S), Including	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
	The Use Of A Balloon Or Mechanical Device, When Used, 1 Or More Needles,	Medical Policy Criteria. Submit for Recommended		
	Includes Imaging Guidance And Bone Biopsy, When Performed	Clinical Review to avoid post-service review.		
0201T	Percutaneous Sacral Augmentation (Sacroplasty), Bilateral Injections, Including	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
	The Use Of A Balloon Or Mechanical Device, When Used, 2 Or More Needles,	Medical Policy Criteria. Submit for Recommended		
	Includes Imaging Guidance And Bone Biopsy, When Performed	Clinical Review to avoid post-service review.		
0202T	Posterior Vertebral Joint(S) Arthroplasty (Eg, Facet Joint[S] Replacement),	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Including Facetectomy, Laminectomy, Foraminotomy, And Vertebral Column	Not subject to pre-service review. Check EIU		
	Fixation, Injection Of Bone Cement, When Performed, Including Fluoroscopy,	policy, which is one of our Clinical Payment and		
	Single Level, Lumbar Spine	Coding Policy (CPCP).		
0207T	Evacuation Of Meibomian Glands, Automated, Using Heat And Intermittent	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
0_0	Pressure, Unilateral	Not subject to pre-service review. Check EIU	07.172020	12/01/2000
	1,1555, 5111,515,	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0208T	Pure Tone Audiometry (Threshold), Automated; Air Only	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
02001	Ture Forte Fladienterly (Three treat, Flatienterlea, Flatienterlea	Medical Policy Criteria. Submit for Recommended	07 172020	12/01/2000
		Clinical Review to avoid post-service review.		
0209T	Pure Tone Audiometry (Threshold), Automated; Air And Bone	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
02001	Tale Tolle Additionally (Theolicia), Additionated, All Alla Bolle	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
0210T	Speech Audiometry Threshold, Automated;	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
02101	opecon radiomotry rinconoid, ratomated,	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
0211T	Speech Audiometry Threshold, Automated; With Speech Recognition	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
02111	Topecon Addionicity Threshold, Addoniated, With Opecon Recognition	Medical Policy Criteria. Submit for Recommended	3/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
0219T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
02101	Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level;	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
	Cervical	policy, which is one of our Clinical Payment and		
	Cervical	Coding Policy (CPCP).		
0220T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
JZZU I	Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level;	Not subject to pre-service review. Check EIU	12/1/2020	12/3/1/2000
	Thoracic	policy, which is one of our Clinical Payment and		
	THOTACIC			
0004T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	10/1/2000	12/31/2999
)221T		_	12/1/2020	12/31/2999
	Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level;	Not subject to pre-service review. Check EIU		
	Lumbar	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

0222T	Placement Of A Posterior Intrafacet Implant(S), Unilateral Or Bilateral, Including	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S), Single Level;	Not subject to pre-service review. Check EIU		1.2.0.1.2.00
	Each Additional Vertebral Segment (List Separately In Addition To Code For	policy, which is one of our Clinical Payment and		
	Primary Procedure)	Coding Policy (CPCP).		
224U	Antibody, Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2)	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	(Coronavirus Disease [Covid-19]), Includes Titer(S), When Performed	Not subject to pre-service review. Check EIU		
	(**************************************	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)226U	Surrogate Viral Neutralization Test (Svnt), Severe Acute Respiratory Syndrome	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]), Elisa, Plasma, Seru			
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
232T	Injection(S), Platelet Rich Plasma, Any Site, Including Image Guidance,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Harvesting And Preparation When Performed	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
253T	Insertion Of Anterior Segment Aqueous Drainage Device, Without Extraocular	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Reservoir, Internal Approach, Into The Suprachoroidal Space	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
263T	Intramuscular Autologous Bone Marrow Cell Therapy, With Preparation Of	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Harvested Cells, Multiple Injections, One Leg, Including Ultrasound Guidance, If	Not subject to pre-service review. Check EIU		
	Performed; Complete Procedure Including Unilateral Or Bilateral Bone Marrow	policy, which is one of our Clinical Payment and		
	Harvest	Coding Policy (CPCP).		
264T	Intramuscular Autologous Bone Marrow Cell Therapy, With Preparation Of	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Harvested Cells, Multiple Injections, One Leg, Including Ultrasound Guidance, If	Not subject to pre-service review. Check EIU		
	Performed; Complete Procedure Excluding Bone Marrow Harvest	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
265T	Intramuscular Autologous Bone Marrow Cell Therapy, With Preparation Of	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Harvested Cells, Multiple Injections, One Leg, Including Ultrasound Guidance, If	Not subject to pre-service review. Check EIU		
	Performed; Unilateral Or Bilateral Bone Marrow Harvest Only For Intramuscular	policy, which is one of our Clinical Payment and		
	Autologous Bone Marrow Cell Therapy	Coding Policy (CPCP).		
266T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Total	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System (Includes Generator Placement, Unilateral Or Bilateral Lead Placement,	Medical Policy Criteria. Submit for Recommended		
	Intra-Operative Interrogation, Programming, And Repositioning, When Performed)	Clinical Review to avoid post-service review.		
267T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Lead	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Only, Unilateral (Includes Intra-Operative Interrogation, Programming, And	Medical Policy Criteria. Submit for Recommended		
	Repositioning, When Performed)	Clinical Review to avoid post-service review.		
268T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Pulse	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Generator Only (Includes Intra-Operative Interrogation, Programming, And	Medical Policy Criteria. Submit for Recommended		
	Repositioning, When Performed)	Clinical Review to avoid post-service review.		
269T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Total System	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	(Includes Generator Placement, Unilateral Or Bilateral Lead Placement, Intra-	Medical Policy Criteria. Submit for Recommended		
	Operative Interrogation, Programming, And Repositioning, When Performed)	Clinical Review to avoid post-service review.		
270T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Lead Only,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Unilateral (Includes Intra-Operative Interrogation, Programming, And	Medical Policy Criteria. Submit for Recommended		
	Repositioning, When Performed)	Clinical Review to avoid post-service review.		
271T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Pulse	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Generator Only (Includes Intra-Operative Interrogation, Programming, And	Medical Policy Criteria. Submit for Recommended		
	Repositioning, When Performed)	Clinical Review to avoid post-service review.		

0272T	Interrogation Device Evaluation (In Person), Carotid Sinus Baroreflex Activation	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System, Including Telemetric Iterative Communication With The Implantable	Medical Policy Criteria. Submit for Recommended		
	Device To Monitor Device Diagnostics And Programmed Therapy Values, With	Clinical Review to avoid post-service review.		
	Interpretation And Report (Eg, Battery Status, Lead Impedance, Pulse Amplitude,			
	Pulse Width, Therapy Frequency, Pathway Mode, Burst Mode, Therapy Start/Stop			
	Times Each Day);			
)273T	Interrogation Device Evaluation (In Person), Carotid Sinus Baroreflex Activation	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System, Including Telemetric Iterative Communication With The Implantable	Medical Policy Criteria. Submit for Recommended		
	Device To Monitor Device Diagnostics And Programmed Therapy Values, With	Clinical Review to avoid post-service review.		
	Interpretation And Report (Eg, Battery Status, Lead Impedance, Pulse Amplitude,	·		
	Pulse Width, Therapy Frequency, Pathway Mode, Burst Mode, Therapy Start/Stop			
	Times Each Day); With Programming			
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Decompression Of Neural Elements, (With Or Without Ligamentous Resection,	Not subject to pre-service review. Check EIU		
	Discectomy, Facetectomy And/Or Foraminotomy), Any Method, Under Indirect	policy, which is one of our Clinical Payment and		
	Image Guidance (Eg, Fluoroscopic, Ct), Single Or Multiple Levels, Unilateral Or	Coding Policy (CPCP).		
	Bilateral; Cervical Or Thoracic	g, (e. e. ).		
0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Decompression Of Neural Elements, (With Or Without Ligamentous Resection,	Not subject to pre-service review. Check EIU		
	Discectomy, Facetectomy And/Or Foraminotomy), Any Method, Under Indirect	policy, which is one of our Clinical Payment and		
	Image Guidance (Eg, Fluoroscopic, Ct), Single Or Multiple Levels, Unilateral Or	Coding Policy (CPCP).		
	Bilateral: Lumbar	g, (e. e. ).		
0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg, Scrambler	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Therapy), Each Treatment Session (Includes Placement Of Electrodes)	Not subject to pre-service review. Check EIU		
	····/	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0308T	Insertion Of Ocular Telescope Prosthesis Including Removal Of Crystalline Lens	MP Criteria: Procedure/service reviewed against	7/1/2012	12/31/2999
	Or Intraocular Lens Prosthesis	Medical Policy Criteria. Submit for Recommended	.,	1.2.0.1.2.00
	51 mm. 25 mm. 25 mm. 1 mm. 25	Clinical Review to avoid post-service review.		
0322U	Neurology (Autism Spectrum Disorder [Asd]), Quantitative Measurements Of 14	EIU: Procedure/service not reimbursed by the Plan.	1/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.2.0.1.2.00
	Tandem Mass Spectrometry (Lc-Ms/Ms), Plasma, Results Reported As Negative	policy, which is one of our Clinical Payment and		
	Or Positive For Risk Of Metabolic Subtypes Associated With Asd	Coding Policy (CPCP).		
0323U	Infectious Agent Detection By Nucleic Acid (Dna And Rna), Central Nervous	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	System Pathogen, Metagenomic Next-Generation Sequencing, Cerebrospinal	Medical Policy Criteria. Submit for Recommended		
	Fluid (Csf), Identification Of Pathogenic Bacteria, Viruses, Parasites, Or Fungi	Clinical Review to avoid post-service review.		
0329T	Monitoring Of Intraocular Pressure For 24 Hours Or Longer, Unilateral Or Bilateral,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	With Interpretation And Report	Medical Policy Criteria. Submit for Recommended		
	1	Clinical Review to avoid post-service review.		
0330T	Tear Film Imaging, Unilateral Or Bilateral, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	J J, 2, 1	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0331T	Myocardial Sympathetic Innervation Imaging, Planar Qualitative And Quantitative	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Assessment;	Medical Policy Criteria. Submit for Recommended		12,5 2000
	, issued in the second of the	Clinical Review to avoid post-service review.		
0332T	Myocardial Sympathetic Innervation Imaging, Planar Qualitative And Quantitative	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
00021	Assessment; With Tomographic Spect	Medical Policy Criteria. Submit for Recommended	5, 1,2020	12/01/2000
	Assessment, with romographic open	Clinical Review to avoid post-service review.		
	1	Cililical Neview to avoid post-service review.		

0335T	Insertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and	12/1/2020	12/31/2999
		Coding Policy (CPCP).		
0337U	Enumeration Of Plasma Cells Based On Differential Cd138, Cd38, Cd19, And Cd45 Protein Biomarker Expression, Peripheral Blood	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0338T	Arterial Puncture, Selective Catheter Placement(S) Renal Artery(les), Fluoroscopy, Contrast Injection(S), Intraprocedural Roadmapping And Radiological Supervision	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0338U	Oncology (Solid Tumor), Circulating Tumor Cell Selection, Identification, Morphological Characterization, Detection And Enumeration Based On Differential Epcam, Cytokeratins 8, 18, And 19, And Cd45 Protein Biomarkers, And Quantification Of Her2 Protein Biomarker?Expressing Cells, Peripheral Blood	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0339T	Arterial Puncture, Selective Catheter Placement(S) Renal Artery(les), Fluoroscopy, Contrast Injection(S), Intraprocedural Roadmapping And Radiological Supervision	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0342T	Therapeutic Apheresis With Selective Hdl Delipidation And Plasma Reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0342U	Oncology (Pancreatic Cancer), Multiplex Immunoassay Of C5, C4, Cystatin C, Factor B, Osteoprotegerin (Opg), Gelsolin, Igfbp3, Ca125 And Multiplex Electrochemiluminescent Immunoassay (Eclia) For Ca19-9, Serum, Diagnostic Algorithm Reported Qualitatively As Positive, Negative, Or Borderline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0344U	Hepatology (Nonalcoholic Fatty Liver Disease [Nafld]), Semiquantitative Evaluation Of 28 Lipid Markers By Liquid Chromatography With Tandem Mass Spectrometry	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach Via The Coronary Sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
0347T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0348T	Radiologic Examination, Radiostereometric Analysis (Rsa); Spine, (Includes Cervical, Thoracic And Lumbosacral, When Performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

0349T	Radiologic Examination, Radiostereometric Analysis (Rsa); Upper Extremity(les),	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	(Includes Shoulder, Elbow, And Wrist, When Performed)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)350T	Radiologic Examination, Radiostereometric Analysis (Rsa); Lower Extremity(les),	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	(Includes Hip, Proximal Femur, Knee, And Ankle, When Performed)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0351T	Optical Coherence Tomography Of Breast Or Axillary Lymph Node, Excised	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Tissue, Each Specimen; Real-Time Intraoperative	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)352T	Optical Coherence Tomography Of Breast Or Axillary Lymph Node, Excised	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Tissue, Each Specimen; Interpretation And Report, Real-Time Or Referred	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0353T	Optical Coherence Tomography Of Breast, Surgical Cavity; Real-Time	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Intraoperative	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0358T	Bioelectrical Impedance Analysis Whole Body Composition Assessment, With	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Interpretation And Report	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna), Gastrointestinal	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Pathogens, 31 Bacterial, Viral, And Parasitic Organisms And Identification Of 21	Not subject to pre-service review. Check EIU		
	Associated Antibiotic-Resistance Genes, Multiplex Amplified Probe Technique	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0375U	Oncology (Ovarian), Biochemical Assays Of 7 Proteins (Follicle Stimulating	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Hormone, Human Epididymis Protein 4, Apolipoprotein A-1, Transferrin, Beta-2	Medical Policy Criteria. Submit for Recommended		
	Macroglobulin, Prealbumin [le, Transthyretin], And Cancer Antigen 125), Algorithm	Clinical Review to avoid post-service review.		
	Reported As Ovarian Cancer Risk Score			
0378T	Visual Field Assessment, With Concurrent Real Time Data Analysis And	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Accessible Data Storage With Patient Initiated Data Transmitted To A Remote	Not subject to pre-service review. Check EIU		
	Surveillance Center For Up To 30 Days; Review And Interpretation With Report By	policy, which is one of our Clinical Payment and		
	A Physician Or Other Qualified Health Care Professional	Coding Policy (CPCP).		
0379T	Visual Field Assessment, With Concurrent Real Time Data Analysis And	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Accessible Data Storage With Patient Initiated Data Transmitted To A Remote	Not subject to pre-service review. Check EIU		
	Surveillance Center For Up To 30 Days; Technical Support And Patient	policy, which is one of our Clinical Payment and		
	Instructions, Surveillance, Analysis, And Transmission Of Daily And Emergent	Coding Policy (CPCP).		
	Data Reports As Prescribed By A Physician Or Other Qualified Health Care			
	Professional			
)397T	Endoscopic Retrograde Cholangiopancreatography (Ercp), With Optical	EIU: Procedure/service not reimbursed by the Plan.	1/1/2016	12/31/2999
	Endomicroscopy (List Separately In Addition To Code For Primary Procedure)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		1212112
)398T	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (Mrgfus),	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	Stereotactic Ablation Lesion, Intracranial For Movement Disorder Including	Medical Policy Criteria. Submit for Recommended		
	Stereotactic Navigation And Frame Placement When Performed	Clinical Review to avoid post-service review.		
0402T	Collagen Cross-Linking Of Cornea, Including Removal Of The Corneal Epithelium,	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
	When Performed, And Intraoperative Pachymetry, When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

0407U	Nephrology (Diabetic Chronic Kidney Disease [Ckd]), Multiplex	MP Criteria: Procedure/service reviewed against	10/1/2024	12/31/2999
	Electrochemiluminescent Immunoassay (Eclia) Of Soluble Tumor Necrosis Factor	Medical Policy Criteria. Submit for Recommended		
	Receptor 1 (Stnfr1), Soluble Tumor Necrosis Receptor 2 (Stnfr2), And Kidney	Clinical Review to avoid post-service review.		
	Injury Molecule 1 (Kim-1) Combined With Clinical Data, Plasma, Algorithm	'		
	Reported As Risk For Progressive Decline In Kidney Function			
408T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Including Contractility Evaluation When Performed, And Programming Of Sensing	Medical Policy Criteria. Submit for Recommended	0, 1,2020	1.2,0.1,2000
	And Therapeutic Parameters; Pulse Generator With Transvenous Electrodes	Clinical Review to avoid post-service review.		
409T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0, 1,2020	1.2,0.1,2000
	And Therapeutic Parameters; Pulse Generator Only	Clinical Review to avoid post-service review.		
410T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
7-101	Including Contractility Evaluation When Performed, And Programming Of Sensing	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
	And Therapeutic Parameters; Atrial Electrode Only	Clinical Review to avoid post-service review.		
)411T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
4111		Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
1410T	And Therapeutic Parameters; Ventricular Electrode Only	Clinical Review to avoid post-service review.	0/4/2020	10/01/0000
)412T	Removal Of Permanent Cardiac Contractility Modulation System; Pulse Generator	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	01110000	10/01/0000
413T	Removal Of Permanent Cardiac Contractility Modulation System; Transvenous	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Electrode (Atrial Or Ventricular)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
414T	Removal And Replacement Of Permanent Cardiac Contractility Modulation	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System Pulse Generator Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)415T	Repositioning Of Previously Implanted Cardiac Contractility Modulation	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Transvenous Electrode (Atrial Or Ventricular Lead)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)416T	Relocation Of Skin Pocket For Implanted Cardiac Contractility Modulation Pulse	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Generator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)417T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Implantable Device To Test The Function Of The Device And Select Optimal	Medical Policy Criteria. Submit for Recommended		
	Permanent Programmed Values With Analysis, Including Review And Report,	Clinical Review to avoid post-service review.		
	Implantable Cardiac Contractility Modulation System	,	1	
)418T	Interrogation Device Evaluation (In Person) With Analysis, Review And Report,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Includes Connection, Recording And Disconnection Per Patient Encounter,	Medical Policy Criteria. Submit for Recommended	0, 1,2020	, 0 ., _ 000
	Implantable Cardiac Contractility Modulation System	Clinical Review to avoid post-service review.		
419T	Destruction Of Neurofibroma, Extensive (Cutaneous, Dermal Extending Into	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	Subcutaneous); Face, Head And Neck, Greater Than 50 Neurofibromas	Medical Policy Criteria. Submit for Recommended	., ., 20 10	12/01/2000
	Cassatanosas, rada, rioda rina resit, Ordator man ou redicinstollas	Clinical Review to avoid post-service review.	1	
420T	Destruction Of Neurofibroma, Extensive (Cutaneous, Dermal Extending Into	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
7201	Subcutaneous); Trunk And Extremities, Extensive, Greater Than 100	Medical Policy Criteria. Submit for Recommended	1/ 1/2010	12/3/1/233
	<i>''</i>	II	1	
140411	Neurofibromas  Opening (Colorectal) Sersoning Quantitative Book Time Terget And Signal	Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
)421U	Oncology (Colorectal) Screening, Quantitative Real-Time Target And Signal	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Amplification Of 8 Rna Markers (Gapdh, Smad4, Acy1, Areg, Cdh1, Kras,	the Plan. Not subject to pre-service review.		
	Tnfrsf10B, Egln2) And Fecal Hemoglobin, Algorithm Reported As A Positive Or			
	Negative For Colorectal Cancer Risk			

0422T	Tactile Breast Imaging By Computer-Aided Tactile Sensors, Unilateral Or Bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
		Clinical Review to avoid post-service review.		
0436U	Oncology (Lung), Plasma Analysis Of 388 Proteins, Using Aptamerbased	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Proteomics Technology, Predictive Algorithm Reported As Clinical Benefit From	Medical Policy Criteria. Submit for Recommended		
	Immune Checkpoint Inhibitor Therapy	Clinical Review to avoid post-service review.		
0440T	Ablation, Percutaneous, Cryoablation, Includes Imaging Guidance, Upper	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Extremity Distal/Peripheral Nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0441T	Ablation, Percutaneous, Cryoablation, Includes Imaging Guidance; Lower	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
	Extremity Distal/Peripheral Nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0442T	Ablation, Percutaneous, Cryoablation, Includes Imaging Guidance; Nerve Plexus	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Or Other Truncal Nerve (Eg, Brachial Plexus, Pudendal Nerve)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0443T	Real-Time Spectral Analysis Of Prostate Tissue By Fluorescence Spectroscopy,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Including Imaging Guidance (List Separately In Addition To Code For Primary	Medical Policy Criteria. Submit for Recommended		
	Procedure)	Clinical Review to avoid post-service review.		
0444U	Oncology (Solid Organ Neoplasia), Targeted Genomic Sequence Analysis Panel	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Of 361 Genes, Interrogation For Gene Fusions, Translocations, Or Other	Medical Policy Criteria. Submit for Recommended		
	Rearrangements, Using Dna From Formalin-Fixed Paraffin-Embedded (Ffpe)	Clinical Review to avoid post-service review.		
	Tumor Tissue, Report Of Clinically Significant Variant(S)			
0446U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]), Analysis Of 10	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Cytokine Soluble Mediator Biomarkers By Immunoassay, Plasma, Individual	Medical Policy Criteria. Submit for Recommended		
	Components Reported With An Algorithmic Risk Score For Current Disease	Clinical Review to avoid post-service review.		
	Activity			
0447U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]), Analysis Of 11	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Cytokine Soluble Mediator Biomarkers By Immunoassay, Plasma, Individual	Medical Policy Criteria. Submit for Recommended		
	Components Reported With An Algorithmic Prognostic Risk Score For Developing	Clinical Review to avoid post-service review.		
	A Clinical Flare	· ·		
0448U	Oncology (Lung And Colon Cancer), Dna, Qualitative, Nextgeneration Sequencing	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Detection Of Single-Nucleotide Variants And Deletions In Egfr And Kras Genes,	Medical Policy Criteria. Submit for Recommended		
	Formalin-Fixed Paraffinembedded (Ffpe) Solid Tumor Samples, Reported As	Clinical Review to avoid post-service review.		
	Presence Or Absence Of Targeted Mutation(S), With Recommended Therapeutic	, i		
	Options			
0449T	Insertion Of Aqueous Drainage Device, Without Extraocular Reservoir, Internal	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	Approach, Into The Subconjunctival Space; Initial Device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0449U	Carrier Screening For Severe Inherited Conditions (Eg, Cystic Fibrosis, Spinal	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Muscular Atrophy, Beta Hemoglobinopathies [Including Sickle Cell Disease], Alpha	Medical Policy Criteria. Submit for Recommended		
	Thalassemia), Regardless Of Race Or Self-Identified Ancestry, Genomic	Clinical Review to avoid post-service review.		
	Sequence Analysis Panel, Must Include Analysis Of 5 Genes (Cftr, Smn1, Hbb,	· ·		
	Hba1, Hba2)			
0450T	Insertion Of Aqueous Drainage Device, Without Extraocular Reservoir, Internal	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Approach, Into The Subconjunctival Space, Each Additional Device (List	Medical Policy Criteria. Submit for Recommended		
	Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
0464T	Visual Evoked Potential, Testing For Glaucoma, With Interpretation And Report		12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

0474T	Insertion Of Anterior Segment Aqueous Drainage Device, With Creation Of	MP Criteria: Procedure/service reviewed against	7/1/2017	12/31/2999
04741		Medical Policy Criteria. Submit for Recommended	7/1/2017	12/31/2999
	Intraocular Reservoir, internal Approach, into The Supraciliary Space	· · · · · · · · · · · · · · · · · · ·		
0481T	Injection(S), Autologous White Blood Cell Concentrate (Autologous Protein	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
J4011		Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
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0483T	Performed Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic	Clinical Review to avoid post-service review.	9/1/2020	10/21/2000
U403 I	Valve; Percutaneous Approach, Including Transseptal Puncture, When Performed	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	valve, Percutarieous Approach, including Transseptal Puncture, when Performed	•		
0484T	Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic	Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
J484 I		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Valve; Transthoracic Exposure (Eg, Thoracotomy, Transapical)	Medical Policy Criteria. Submit for Recommended		
0.405T	Outlies LOute was a Transaction (Out) Of Middle Fee With later was to fine And	Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
0485T		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0486T		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0489T		MP Criteria: Procedure/service reviewed against	6/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Including Incubation With Cell Dissociation Enzymes, Removal Of Non-Viable	Clinical Review to avoid post-service review.		
	Cells And Debris, Determination Of Concentration And Dilution Of Regenerative			
	Cells			
0490T		MP Criteria: Procedure/service reviewed against	6/1/2022	12/31/2999
	Hands; Multiple Injections In One Or Both Hands	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0494T		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Lung(S) To Ex Vivo Organ Perfusion System, Including Decannulation, Separation	1		
	, ,	Clinical Review to avoid post-service review.		
	Implantation, When Performed			
0495T		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Physiological And Laboratory Assessment (Eg, Pulmonary Artery Flow, Pulmonary	Clinical Review to avoid post-service review.		
	Artery Pressure, Left Atrial Pressure, Pulmonary Vascular Resistance, Mean/Peak			
	And Plateau Airway Pressure, Dynamic Compliance And Perfusate Gas Analysis),			
	Including Bronchoscopy And X Ray When Performed; First Two Hours In Sterile			
	Field			
0496T		MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Physiological And Laboratory Assessment (Eg, Pulmonary Artery Flow, Pulmonary			
	Artery Pressure, Left Atrial Pressure, Pulmonary Vascular Resistance, Mean/Peak			
	And Plateau Airway Pressure, Dynamic Compliance And Perfusate Gas Analysis),			
	Including Bronchoscopy And X Ray When Performed; Each Additional Hour (List			
	Separately In Addition To Code For Primary Procedure)			
0507T	Near Infrared Dual Imaging (Ie, Simultaneous Reflective And Transilluminated	EIU: Procedure/service not reimbursed by the Plan.	7/1/2018	12/31/2999
	Light) Of Meibomian Glands, Unilateral Or Bilateral, With Interpretation And Report	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

0509T	Electroretinography (Erg) With Interpretation And Report, Pattern (Perg)	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
510T	Removal Of Sinus Tarsi Implant	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
511T	Removal And Reinsertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		1-1-1-1-1-1-1
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
512T	Extracorporeal Shock Wave For Integumentary Wound Healing, Including Topical	EIU: Procedure/service not reimbursed by the Plan.	1/1/2019	12/31/2999
	Application And Dressing Care; Initial Wound	Not subject to pre-service review. Check EIU	., ., _ 0 . 0	12/01/2000
	Application And Dicesting Care, milital Would	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
513T	Extracorporeal Shock Wave For Integumentary Wound Healing, Including Topical	EIU: Procedure/service not reimbursed by the Plan.	1/1/2010	12/31/2999
0101	Application And Dressing Care; Each Additional Wound (List Separately In	Not subject to pre-service review. Check EIU	1/1/2013	12/3/1/2333
	Addition To Code For Primary Procedure)	policy, which is one of our Clinical Payment and		
	Addition to Gode For Primary Procedure)	j. 37		
FAET	In a still a Of Windows Conding Office I at a Figure 1 of Washington Decision Including	Coding Policy (CPCP).	0/4/0000	40/04/0000
515T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Device Interrogation And Programming, And Imaging Supervision And	Medical Policy Criteria. Submit for Recommended		
	Interpretation, When Performed; Complete System (Includes Electrode And	Clinical Review to avoid post-service review.		
	Generator [Transmitter And Battery])			
516T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Device Interrogation And Programming, And Imaging Supervision And	Medical Policy Criteria. Submit for Recommended		
	Interpretation, When Performed; Electrode Only	Clinical Review to avoid post-service review.		
517T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Device Interrogation And Programming, And Imaging Supervision And	Medical Policy Criteria. Submit for Recommended		
	Interpretation, When Performed; Both Components Of Pulse Generator (Battery	Clinical Review to avoid post-service review.		
	And Transmitter) Only			
518T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Pacing; Battery Component Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
519T	Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	For Left Ventricular Pacing, Including Device Interrogation And Programming, Both	Medical Policy Criteria. Submit for Recommended		
	Components (Battery And Transmitter)	Clinical Review to avoid post-service review.		
520T	Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	For Left Ventricular Pacing, Including Device Interrogation And Programming;	Medical Policy Criteria. Submit for Recommended		
	Battery Component Only	Clinical Review to avoid post-service review.		
521T	Interrogation Device Evaluation (In Person) With Analysis, Review And Report,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Includes Connection, Recording, And Disconnection Per Patient Encounter,	Medical Policy Criteria. Submit for Recommended		
	Wireless Cardiac Stimulator For Left Ventricular Pacing	Clinical Review to avoid post-service review.		
522T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
<del></del> •	Implantable Device To Test The Function Of The Device And Select Optimal	Medical Policy Criteria. Submit for Recommended		1.2,0.,2000
	Permanent Programmed Values With Analysis, Including Review And Report,	Clinical Review to avoid post-service review.		
	Wireless Cardiac Stimulator For Left Ventricular Pacing	Ominical Neview to avoid post-service review.		
524T	Endovenous Catheter Directed Chemical Ablation With Balloon Isolation Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
JZ# I		Medical Policy Criteria. Submit for Recommended	3/1/2020	12/31/2999
	Incompetent Extremity Vein, Open Or Percutaneous, Including All Vascular	•		
	Access, Catheter Manipulation, Diagnostic Imaging, Imaging Guidance And	Clinical Review to avoid post-service review.		
	Monitoring		I	

)525T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
00201	Testing Of The Lead And Monitor, Initial System Programming, And Imaging	Medical Policy Criteria. Submit for Recommended	3/1/2020	12/01/2000
	Supervision And Interpretation; Complete System (Electrode And Implantable	Clinical Review to avoid post-service review.		
	Monitor)	Cililical Neview to avoid post-service review.		
526T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Testing Of The Lead And Monitor, Initial System Programming, And Imaging	Medical Policy Criteria. Submit for Recommended		
	Supervision And Interpretation; Electrode Only	Clinical Review to avoid post-service review.		
527T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System, Including	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Testing Of The Lead And Monitor, Initial System Programming, And Imaging	Medical Policy Criteria. Submit for Recommended		
	Supervision And Interpretation; Implantable Monitor Only	Clinical Review to avoid post-service review.		
528T	Programming Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System With Iterative Adjustment Of Programmed Values, With Analysis, Review,	Medical Policy Criteria. Submit for Recommended		
	And Report	Clinical Review to avoid post-service review.		
529T	Interrogation Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	System With Analysis, Review, And Report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
530T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Supervision And Interpretation; Complete System (Electrode And Implantable	Medical Policy Criteria. Submit for Recommended		
	Monitor)	Clinical Review to avoid post-service review.		
531T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Supervision And Interpretation; Electrode Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
532T	Removal Of Intracardiac Ischemia Monitoring System, Including All Imaging	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Supervision And Interpretation; Implantable Monitor Only	Medical Policy Criteria. Submit for Recommended		1
	Capar noise rate into protessing implantable monitor only	Clinical Review to avoid post-service review.		
537T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Harvesting Of Blood-Derived T	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
	Lymphocytes For Development Of Genetically Modified Autologous Car-T Cells,	Medical Policy Criteria. Submit for Recommended	0, 10, 202 .	12/01/2000
	Per Day	Clinical Review to avoid post-service review.		
538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Preparation Of Blood-Derived	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
	T Lymphocytes For Transportation (Eg, Cryopreservation, Storage)	Medical Policy Criteria. Submit for Recommended	0, 10, 2021	1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
		Clinical Review to avoid post-service review.		
539T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt And Preparation Of	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
	Car-T Cells For Administration	Medical Policy Criteria. Submit for Recommended	0, 10, 2021	12/01/2000
	out i done i di Autiminatationi	Clinical Review to avoid post-service review.		
540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Car-T Cell Administration,	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
	Autologous	Medical Policy Criteria. Submit for Recommended	0, 10, 2021	12/01/2000
	, id. ologodo	Clinical Review to avoid post-service review.		
544T	Transcatheter Mitral Valve Annulus Reconstruction, With Implantation Of	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
5111	Adjustable Annulus Reconstruction Device, Percutaneous Approach Including	Medical Policy Criteria. Submit for Recommended	10/1/2022	12/01/2000
	Transseptal Puncture	Clinical Review to avoid post-service review.		
545T	Transcatheter Tricuspid Valve Annulus Reconstruction With Implantation Of	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Adjustable Annulus Reconstruction Device, Percutaneous Approach	Medical Policy Criteria. Submit for Recommended	5, 1/2020	12/01/2000
	, agastable / fillialias (1000) istraction Device, 1 croataneous Approach	Clinical Review to avoid post-service review.		
546T	Radiofrequency Spectroscopy, Real Time, Intraoperative Margin Assessment, At	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
7701	The Time Of Partial Mastectomy, With Report	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2333
	The Time Of Fartial Mastectority, With Nepolt	Clinical Review to avoid post-service review.		
547T	Bone-Material Quality Testing By Microindentation(S) Of The Tibia(S), With	Non Covered: Procedure/service not covered by	7/1/2019	12/31/2999
)+ <i>i</i> 1		· · · · · · · · · · · · · · · · · · ·	7/1/2019	12/31/2999
	Results Reported As A Score	the Plan. Not subject to pre-service review.		

0552T	Low-Level Laser Therapy, Dynamic Photonic And Dynamic Thermokinetic Energies, Provided By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against	12/15/2020	12/31/2999
	Ellergies, Flovided by A Filysician Of Other Qualified health Care Floressional	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
563T	Evacuation Of Meibomian Glands, Using Heat Delivered Through Wearable, Open-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Eye Eyelid Treatment Devices And Manual Gland Expression, Bilateral	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)565T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	Osteoarthritis Of The Knees; Tissue Harvesting And Cellular Implant Creation	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)566T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	Osteoarthritis Of The Knees; Injection Of Cellular Implant Into Knee Joint Including	Not subject to pre-service review. Check EIU		
	Ultrasound Guidance, Unilateral	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0569T	Transcatheter Tricuspid Valve Repair, Percutaneous Approach; Initial Prosthesis	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0570T	Transcatheter Tricuspid Valve Repair, Percutaneous Approach; Each Additional	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Prosthesis During Same Session (List Separately In Addition To Code For Primary			
	Procedure)	Clinical Review to avoid post-service review.		
)587T	Percutaneous Implantation Or Replacement Of Integrated Single Device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	Neurostimulation System For Bladder Dysfunction Including Electrode Array And	Medical Policy Criteria. Submit for Recommended		
	Receiver Or Pulse Generator, Including Analysis, Programming, And Imaging	Clinical Review to avoid post-service review.		
	Guidance When Performed, Posterior Tibial Nerve	Tommoun noview to avoid poor solvies leview.		
0588T	Revision Or Removal Of Percutaneously Placed Integrated Single Device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	Neurostimulation System For Bladder Dysfunction Including Electrode Array And	Medical Policy Criteria. Submit for Recommended	0, 1,202	.2,0.,2000
	Receiver Or Pulse Generator, Including Analysis, Programming, And Imaging	Clinical Review to avoid post-service review.		
	Guidance When Performed, Posterior Tibial Nerve	Chillipan Neview to avoid post service review.		
0589T	Electronic Analysis With Simple Programming Of Implanted Integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	Neurostimulation System For Bladder Dysfunction (Eg, Electrode Array And	Medical Policy Criteria. Submit for Recommended	0, 1,202	.2,0.,2000
	Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz),	Clinical Review to avoid post-service review.		
	On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive	Chillion Review to avoid post service review.		
	Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive			
	Parameters, When Performed By Physician Or Other Qualified Health Care			
	Professional, Posterior Tibial Nerve, 1-3 Parameters			
0590T	Electronic Analysis With Complex Programming Of Implanted Integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
00001	Neurostimulation System For Bladder Dysfunction (Eg, Electrode Array And	Medical Policy Criteria. Submit for Recommended	3/1/2021	12/31/2999
	Receiver), Including Contact Group(S), Amplitude, Pulse Width, Frequency (Hz),	Clinical Review to avoid post-service review.		
		Chilical Neview to avoid post-service review.		
	On/Off Cycling, Burst, Dose Lockout, Patient-Selectable Parameters, Responsive			
	Neurostimulation, Detection Algorithms, Closed-Loop Parameters, And Passive			
	Parameters, When Performed By Physician Or Other Qualified Health Care			
NEGET	Professional, Posterior Tibial Nerve, 4 Or More Parameters	MD Critoria, Dragoduro/ocmies reviewed accinet	11/15/2022	10/01/0000
0596T	Temporary Female Intraurethral Valve-Pump (Ie, Voiding Prosthesis); Initial	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	Insertion, Including Urethral Measurement	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0597T	Temporary Female Intraurethral Valve-Pump (Ie, Voiding Prosthesis);	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	Replacement	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

0598T	Noncontact Real-Time Fluorescence Wound Imaging, For Bacterial Presence,	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Location, And Load, Per Session; First Anatomic Site (Eg, Lower Extremity)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0599T	Noncontact Real-Time Fluorescence Wound Imaging, For Bacterial Presence,	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Location, And Load, Per Session; Each Additional Anatomic Site (Eg, Upper	Not subject to pre-service review. Check EIU		
	Extremity) (List Separately In Addition To Code For Primary Procedure)	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0600T	Ablation, Irreversible Electroporation; 1 Or More Tumors Per Organ, Including	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Imaging Guidance, When Performed, Percutaneous	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0601T	Ablation, Irreversible Electroporation; 1 Or More Tumors Per Organ, Including	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Fluoroscopic And Ultrasound Guidance, When Performed, Open	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0602T	Glomerular Filtration Rate (Gfr) Measurement(S), Transdermal, Including Sensor	EIU: Procedure/service not reimbursed by the Plan.	4/1/2021	12/31/2999
	Placement And Administration Of A Single Dose Of Fluorescent Pyrazine Agent	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0603T	Glomerular Filtration Rate (Gfr) Monitoring, Transdermal, Including Sensor	EIU: Procedure/service not reimbursed by the Plan.	4/1/2021	12/31/2999
	Placement And Administration Of More Than One Dose Of Fluorescent Pyrazine	Not subject to pre-service review. Check EIU		
	Agent, Each 24 Hours	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0615T	Eye-Movement Analysis Without Spatial Calibration, With Interpretation And	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Report	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And	- · · · · · · · · · · · · · · · · · · ·	7/1/2024	12/31/2999
	Drug Delivery, Including Transrectal Ultrasound And Fluoroscopy, When	Not subject to pre-service review. Check EIU		
	Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0620T	Endovascular Venous Arterialization, Tibial Or Peroneal Vein, With Transcatheter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Placement Of Intravascular Stent Graft(S) And Closure By Any Method, Including	Not subject to pre-service review. Check EIU		
	Percutaneous Or Open Vascular Access, Ultrasound Guidance For Vascular	policy, which is one of our Clinical Payment and		
	Access When Performed, All Catheterization(S) And Intraprocedural Roadmapping	Coding Policy (CPCP).		
	And Imaging Guidance Necessary To Complete The Intervention, All Associated			
	Radiological Supervision And Interpretation, When Performed			
0621T	Trabeculostomy Ab Interno By Laser;	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0622T	Trabeculostomy Ab Interno By Laser; With Use Of Ophthalmic Endoscope	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0623T	Automated Quantification And Characterization Of Coronary Atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary	Not subject to pre-service review. Check EIU		
	Computed Tomographic Angiography; Data Preparation And Transmission,	policy, which is one of our Clinical Payment and		
	Computerized Analysis Of Data, With Review Of Computerized Analysis Output To	Coding Policy (CPCP).		
	Reconcile Discordant Data, Interpretation And Report			

624T	Automated Quantification And Characterization Of Coronary Atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary	Not subject to pre-service review. Check EIU		
	Computed Tomographic Angiography; Data Preparation And Transmission	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
325T	Automated Quantification And Characterization Of Coronary Atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary	Not subject to pre-service review. Check EIU		
	Computed Tomographic Angiography; Computerized Analysis Of Data From	policy, which is one of our Clinical Payment and		
	Coronary Computed Tomographic Angiography	Coding Policy (CPCP).		
26T	Automated Quantification And Characterization Of Coronary Atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Plaque To Assess Severity Of Coronary Disease, Using Data From Coronary	Not subject to pre-service review. Check EIU		
	Computed Tomographic Angiography; Review Of Computerized Analysis Output	policy, which is one of our Clinical Payment and		
	To Reconcile Discordant Data, Interpretation And Report	Coding Policy (CPCP).		
27T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Intervertebral Disc, Unilateral Or Bilateral Injection, With Fluoroscopic Guidance,	Not subject to pre-service review. Check EIU		
	Lumbar; First Level	policy, which is one of our Clinical Payment and		
	'	Coding Policy (CPCP).		
28T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Intervertebral Disc, Unilateral Or Bilateral Injection, With Fluoroscopic Guidance,	Not subject to pre-service review. Check EIU	., .,	
	Lumbar; Each Additional Level (List Separately In Addition To Code For Primary	policy, which is one of our Clinical Payment and		
	Procedure)	Coding Policy (CPCP).		
29T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Intervertebral Disc, Unilateral Or Bilateral Injection, With Ct Guidance, Lumbar;	Not subject to pre-service review. Check EIU		
	First Level	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
30T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Intervertebral Disc, Unilateral Or Bilateral Injection, With Ct Guidance, Lumbar;	Not subject to pre-service review. Check EIU	., ., _ 0	.2,0.,2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
31T	Transcutaneous Visible Light Hyperspectral Imaging Measurement Of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Oxyhemoglobin, Deoxyhemoglobin, And Tissue Oxygenation, With Interpretation	Not subject to pre-service review. Check EIU		
	And Report, Per Extremity	policy, which is one of our Clinical Payment and		
	, 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Coding Policy (CPCP).		
32T	Percutaneous Transcatheter Ultrasound Ablation Of Nerves Innervating The	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Pulmonary Arteries, Including Right Heart Catheterization, Pulmonary Artery	Medical Policy Criteria. Submit for Recommended	., .,	
	Angiography, And All Imaging Guidance	Clinical Review to avoid post-service review.		
39T	Wireless Skin Sensor Thermal Anisotropy Measurement(S) And Assessment Of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	Flow In Cerebrospinal Fluid Shunt, Including Ultrasound Guidance, When	Not subject to pre-service review. Check EIU		
	Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
40T	Noncontact Near-Infrared Spectroscopy (Eg, For Measurement Of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2999
	Deoxyhemoglobin, Oxyhemoglobin, And Ratio Of Tissue Oxygenation), Other	Not subject to pre-service review. Check EIU		
	Than For Screening For Peripheral Arterial Disease, Image Acquisition,	policy, which is one of our Clinical Payment and		
	Interpretation, And Report; First Anatomic Site	Coding Policy (CPCP).		
43T	Transcatheter Left Ventricular Restoration Device Implantation Including Right And		7/1/2021	12/31/2999
	Left Heart Catheterization And Left Ventriculography When Performed, Arterial	Medical Policy Criteria. Submit for Recommended		
	Approach	Clinical Review to avoid post-service review.		
45T	Transcatheter Implantation Of Coronary Sinus Reduction Device Including	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	Vascular Access And Closure, Right Heart Catheterization, Venous Angiography,	Medical Policy Criteria. Submit for Recommended	=== .	1 = 1 : 1 = 000
	Coronary Sinus Angiography, Imaging Guidance, And Supervision And	Clinical Review to avoid post-service review.		
	Interpretation, When Performed	Similar Noviow to avoid post-solvide leview.	1	

0646T	Transcatheter Tricuspid Valve Implantation (Ttvi)/Replacement With Prosthetic	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	Valve, Percutaneous Approach, Including Right Heart Catheterization, Temporary Pacemaker Insertion, And Selective Right Ventricular Or Right Atrial Angiography, When Performed	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
650T	Programming Device Evaluation (Remote) Of Subcutaneous Cardiac Rhythm Monitor System, With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanently Programmed Values With Analysis, Review And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
651T	Magnetically Controlled Capsule Endoscopy, Esophagus Through Stomach, Including Intraprocedural Positioning Of Capsule, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0656T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0657T	Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0658T	Electrical Impedance Spectroscopy Of 1 Or More Skin Lesions For Automated Melanoma Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
0664T	Donor Hysterectomy (Including Cold Preservation); Open, From Cadaver Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
9665T	Donor Hysterectomy (Including Cold Preservation); Open, From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
9666T	Donor Hysterectomy (Including Cold Preservation); Laparoscopic Or Robotic, From Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
667T	Donor Hysterectomy (Including Cold Preservation); Recipient Uterus Allograft Transplantation From Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
668T		EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0669T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

0670T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	Transplantation; Arterial Anastomosis, Each	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)672T	Endovaginal Cryogen-Cooled, Monopolar Radiofrequency Remodeling Of The	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary	Not subject to pre-service review. Check EIU		
	Incontinence	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0692T	Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0714T	Transperineal Laser Ablation Of Benign Prostatic Hyperplasia, Including Imaging	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Guidance; Prostate Volume Less Than 50 Ml	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0716T	Cardiac Acoustic Waveform Recording With Automated Analysis And Generation	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Of Coronary Artery Disease Risk Score	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0717T	Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Thickness Rotator Cuff Tear; Adipose Tissue Harvesting, Isolation And	Medical Policy Criteria. Submit for Recommended		
	Preparation Of Harvested Cells, Including Incubation With Cell Dissociation	Clinical Review to avoid post-service review.		
	Enzymes, Filtration, Washing, And Concentration Of Adrcs	·		
0718T	Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Thickness Rotator Cuff Tear; Injection Into Supraspinatus Tendon Including	Medical Policy Criteria. Submit for Recommended		
	Ultrasound Guidance, Unilateral	Clinical Review to avoid post-service review.		
0719T	Posterior Vertebral Joint Replacement, Including Bilateral Facetectomy,	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Laminectomy, And Radical Discectomy, Including Imaging Guidance, Lumbar	Medical Policy Criteria. Submit for Recommended		
	Spine, Single Segment	Clinical Review to avoid post-service review.		
0720T	Percutaneous Electrical Nerve Field Stimulation, Cranial Nerves, Without	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Implantation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0721T	Quantitative Computed Tomography (Ct) Tissue Characterization, Including	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Interpretation And Report, Obtained Without Concurrent Ct Examination Of Any	Medical Policy Criteria. Submit for Recommended		
	Structure Contained In Previously Acquired Diagnostic Imaging	Clinical Review to avoid post-service review.		
0722T	Quantitative Computed Tomography (Ct) Tissue Characterization, Including	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Interpretation And Report, Obtained With Concurrent Ct Examination Of Any	Medical Policy Criteria. Submit for Recommended		
	Structure Contained In The Concurrently Acquired Diagnostic Imaging Dataset	Clinical Review to avoid post-service review.		
	(List Separately In Addition To Code For Primary Procedure)			
0723T	Quantitative Magnetic Resonance Cholangiopancreatography (Qmrcp), Including	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Data Preparation And Transmission, Interpretation And Report, Obtained Without	Medical Policy Criteria. Submit for Recommended		
	Diagnostic Magnetic Resonance Imaging (Mri) Examination Of The Same	Clinical Review to avoid post-service review.		
	Anatomy (Eg, Organ, Gland, Tissue, Target Structure) During The Same Session			
0724T	Quantitative Magnetic Resonance Cholangiopancreatography (Qmrcp), Including	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Data Preparation And Transmission, Interpretation And Report, Obtained With	Medical Policy Criteria. Submit for Recommended		
	Diagnostic Magnetic Resonance Imaging (Mri) Examination Of The Same	Clinical Review to avoid post-service review.		
	Anatomy (Eg, Organ, Gland, Tissue, Target Structure) (List Separately In Addition	·		
	To Code For Primary Procedure)			
0725T	Vestibular Device Implantation, Unilateral	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

0726T	Removal Of Implanted Vestibular Device, Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2022	12/31/2999
		Clinical Review to avoid post-service review.		
727T	Removal And Replacement Of Implanted Vestibular Device, Unilateral	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
1211	Tremoval And Treplacement Of Implanted Vestibular Device, Official	Medical Policy Criteria. Submit for Recommended	17172022	12/31/2999
		Clinical Review to avoid post-service review.		
728T	Diagnostic Analysis Of Vestibular Implant, Unilateral; With Initial Programming	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
7201	Diagnostic Analysis of Vestibular Implant, Official, With Initial Flogramming	Medical Policy Criteria. Submit for Recommended	17172022	12/01/2000
		Clinical Review to avoid post-service review.		
729T	Diagnostic Analysis Of Vestibular Implant, Unilateral; With Subsequent	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
1251	Programming	Medical Policy Criteria. Submit for Recommended	17172022	12/01/2000
	1 Togramming	Clinical Review to avoid post-service review.		
730T	Trabeculotomy By Laser, Including Optical Coherence Tomography (Oct)	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
7 30 1	Guidance	Medical Policy Criteria. Submit for Recommended	17172022	12/31/2999
	Guidance	Clinical Review to avoid post-service review.		
731T	Augmentative Ai-Based Facial Phenotype Analysis With Report	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
7011	Augmentative Al-Dased Lacial Enemotype Analysis With Report	Medical Policy Criteria. Submit for Recommended	11112022	12/3/1/2999
		Clinical Review to avoid post-service review.		
732T	Immunotherapy Administration With Electroporation, Intramuscular	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
1321	Infilitutionerapy Administration with Electroporation, intramuscular	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
		Clinical Review to avoid post-service review.		
733T	Remote Real-Time, Motion Capture-Based Neurorehabilitative Therapy Ordered	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
7331	By A Physician Or Other Qualified Health Care Professional; Supply And	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
70 AT	Technical Support, Per 30 Days  Remote Real-Time, Motion Capture-Based Neurorehabilitative Therapy Ordered	Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
734T		MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	By A Physician Or Other Qualified Health Care Professional; Treatment	Medical Policy Criteria. Submit for Recommended		
	Management Services By A Physician Or Other Qualified Health Care	Clinical Review to avoid post-service review.		
70.FT	Professional, Per Calendar Month	MD Odtodo Doordood oo daadaa aaadaa aaadaa aa	7/4/0000	40/04/0000
735T	Preparation Of Tumor Cavity, With Placement Of A Radiation Therapy Applicator	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	For Intraoperative Radiation Therapy (lort) Concurrent With Primary Craniotomy	Medical Policy Criteria. Submit for Recommended		
707T	(List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.	7/4/0000	40/04/0000
737T	Xenograft Implantation Into The Articular Surface	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
740T	Donata Autoropea Alexaithea Donat Donata and the Control Control Control	Clinical Review to avoid post-service review.	9/1/2023	40/04/0000
7401	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose		9/1/2023	12/31/2999
	Calculation And Titration; Initial Set-Up And Patient Education	Medical Policy Criteria. Submit for Recommended		
744	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose	Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
741T		MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
	Calculation And Titration; Provision Of Software, Data Collection, Transmission,	Medical Policy Criteria. Submit for Recommended		
743T	And Storage, Each 30 Days	Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
7431	Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional		1/1/2023	12/31/2999
	Data And Bone Mineral Density (Bmd), With Concurrent Vertebral Fracture	Not subject to pre-service review. Check EIU		
	Assessment, Utilizing Data From A Computed Tomography Scan, Retrieval And	policy, which is one of our Clinical Payment and		
	Transmission Of The Scan Data, Measurement Of Bone Strength And Bmd And	Coding Policy (CPCP).		
	Classification Of Any Vertebral Fractures, With Overall Fracture-Risk Assessment,			
7.1.1	Interpretation And Report	EUL B	0/4/0000	10/04/2000
744T		EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	Imaging Guidance, When Performed, Including Autogenous Or Nonautogenous	Not subject to pre-service review. Check EIU		
	Patch Graft (Eg, Polyester, Eptfe, Bovine Pericardium), When Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

0745T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Noninvasive Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus), Derived From	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	6/15/2023	12/31/2999
	Anatomical Image Data (Eg, Ct, Mri, Or Myocardial Perfusion Scan) And Electrical Data (Eg, 12-Lead Ecg Data), And Identification Of Areas Of Avoidance	Clinical Review to avoid post-service review.		
0746T	Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Into A Multidimensional Radiation Treatment Plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0747T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Delivery Of Radiation Therapy, Arrhythmia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0748T	Injections Of Stem Cell Product Into Perianal Perifistular Soft Tissue, Including Fistula Preparation (Eg, Removal Of Setons, Fistula Curettage, Closure Of Internal Openings)	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0764T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg, Low-Ejection Fraction, Pulmonary Hypertension, Hypertrophic Cardiomyopathy); Related To Concurrently Performed Electrocardiogram (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg, Low-Ejection Fraction, Pulmonary Hypertension, Hypertrophic Cardiomyopathy); Related To Previously Performed Electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0766T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse, Peripheral Nerve, With Identification And Marking Of The Treatment Location, Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization), When Performed; First Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0767T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse, Peripheral Nerve, With Identification And Marking Of The Treatment Location, Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization), When Performed; Each Additional Nerve (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0770T	Virtual Reality Technology To Assist Therapy (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0771T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports, Requiring The Presence Of An Independent, Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Initial 15 Minutes Of Intraservice Time, Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports, Requiring The Presence Of An Independent, Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

0773T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and	9/1/2023	12/31/2999
	Service That The Vr Procedural Dissociation Supports; Initial 15 Minutes Of Intraservice Time, Patient Age 5 Years Or Older	Coding Policy (CPCP).		
0774T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0776T	Therapeutic Induction Of Intra-Brain Hypothermia, Including Placement Of A Mechanical Temperature-Controlled Cooling Device To The Neck Over Carotids And Head, Including Monitoring (Eg, Vital Signs And Sport Concussion Assessment Tool 5 [Scat5]), 30 Minutes Of Treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0777T	Real-Time Pressure-Sensing Epidural Guidance System (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0778T	Surface Mechanomyography (Smmg) With Concurrent Application Of Inertial Measurement Unit (Imu) Sensors For Measurement Of Multi-Joint Range Of Motion, Posture, Gait, And Muscle Function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0779T	Gastrointestinal Myoelectrical Activity Study, Stomach Through Colon, With Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0780T	Instillation Of Fecal Microbiota Suspension Via Rectal Enema Into Lower Gastrointestinal Tract	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
0781T	Bronchoscopy, Rigid Or Flexible, With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves, Including Fluoroscopic Guidance When Performed; Bilateral Mainstem Bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0782T	Bronchoscopy, Rigid Or Flexible, With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves, Including Fluoroscopic Guidance When Performed; Unilateral Mainstem Bronchus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0783T	Transcutaneous Auricular Neurostimulation, Set-Up, Calibration, And Patient Education On Use Of Equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0784T	Insertion Or Replacement Of Percutaneous Electrode Array, Spinal, With Integrated Neurostimulator, Including Imaging Guidance, When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0785T	Revision Or Removal Of Neurostimulator Electrode Array, Spinal, With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

0786T	Insertion Or Replacement Of Percutaneous Electrode Array, Sacral, With	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Integrated Neurostimulator, Including Imaging Guidance, When Performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0787T	Revision Or Removal Of Neurostimulator Electrode Array, Sacral, With Integrated	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Neurostimulator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		12212
0788T	Electronic Analysis With Simple Programming Of Implanted Integrated	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Neurostimulation System (Eg, Electrode Array And Receiver), Including Contact	Medical Policy Criteria. Submit for Recommended		
	Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose	Clinical Review to avoid post-service review.		
	Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection			
	Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed			
	By Physician Or Other Qualified Health Care Professional, Spinal Cord Or Sacral			
	Nerve, 1-3 Parameters			
0789T	Electronic Analysis With Complex Programming Of Implanted Integrated	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Neurostimulation System (Eg, Electrode Array And Receiver), Including Contact	Medical Policy Criteria. Submit for Recommended		
	Group(S), Amplitude, Pulse Width, Frequency (Hz), On/Off Cycling, Burst, Dose	Clinical Review to avoid post-service review.		
	Lockout, Patient-Selectable Parameters, Responsive Neurostimulation, Detection			
	Algorithms, Closed-Loop Parameters, And Passive Parameters, When Performed			
	By Physician Or Other Qualified Health Care Professional, Spinal Cord Or Sacral			
	Nerve, 4 Or More Parameters			
0790T	Revision (Eg, Augmentation, Division Of Tether), Replacement, Or Removal Of	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Thoracolumbar Or Lumbar Vertebral Body Tethering, Including Thoracoscopy,	Not subject to pre-service review. Check EIU		
	When Performed	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0791T	Motor-Cognitive, Semi-Immersive Virtual Reality-Facilitated Gait Training, Each 15	•	7/1/2023	12/31/2999
	Minutes (List Separately In Addition To Code For Primary Procedure)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
0792T	Application Of Cityan Diamaina Flyanida 200/ Dy A Physician On Other Ovalified	Coding Policy (CPCP).  Non Covered: Procedure/service not covered by	7/1/2023	40/04/0000
0/921	Application Of Silver Diamine Fluoride 38%, By A Physician Or Other Qualified		7/1/2023	12/31/2999
0793T	Health Care Professional Percutaneous Transcatheter Thermal Ablation Of Nerves Innervating The	the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
0/931	Pulmonary Arteries, Including Right Heart Catheterization, Pulmonary Artery	Medical Policy Criteria. Submit for Recommended	7/1/2023	12/31/2999
	Angiography, And All Imaging Guidance	Clinical Review to avoid post-service review.		
0794T	Patient-Specific, Assistive, Rules-Based Algorithm For Ranking Pharmaco-	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
07341	Oncologic Treatment Options Based On The Patient'S Tumor-Specific Cancer	Medical Policy Criteria. Submit for Recommended	77172023	12/3/1/2999
	Marker Information Obtained From Prior Molecular Pathology,	Clinical Review to avoid post-service review.		
	Immunohistochemical, Or Other Pathology Results Which Have Been Previously	official review to avoid post-service review.		
	Interpreted And Reported Separately			
0795T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
01001	Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial	Medical Policy Criteria. Submit for Recommended	17.172020	12/01/2000
	Angiography, Right Ventriculography, Femoral Venography) And Device	Clinical Review to avoid post-service review.		
	Evaluation (Eg, Interrogation Or Programming), When Performed; Complete	ominoar review to avoid poor convice review.		
	System (le, Right Atrial And Right Ventricular Pacemaker Components)			
0796T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial	Medical Policy Criteria. Submit for Recommended		
	Angiography, Right Ventriculography, Femoral Venography) And Device	Clinical Review to avoid post-service review.		
	Evaluation (Eg, Interrogation Or Programming), When Performed; Right Atrial	Carried Atom to arong poor contribution.		
İ	Pacemaker Component (When An Existing Right Ventricular Single Leadless			
	Pacemaker Exists To Create A Dual-Chamber Leadless Pacemaker System)		1	

0797T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
07071		Medical Policy Criteria. Submit for Recommended	17172020	12/01/2000
	Angiography, Right Ventriculography, Femoral Venography) And Device	Clinical Review to avoid post-service review.		
	Evaluation (Eg, Interrogation Or Programming), When Performed; Right	Cirilical Neview to avoid poor service review.		
	Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless			
	Pacemaker System)			
0798T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial	Medical Policy Criteria. Submit for Recommended		
	Angiography, Right Ventriculography, Femoral Venography), When Performed;	Clinical Review to avoid post-service review.		
	Complete System (Ie, Right Atrial And Right Ventricular Pacemaker Components)			
0799T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial	Medical Policy Criteria. Submit for Recommended		
	Angiography, Right Ventriculography, Femoral Venography), When Performed;	Clinical Review to avoid post-service review.		
	Right Atrial Pacemaker Component			
0800T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
l	Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound, Right Atrial	Medical Policy Criteria. Submit for Recommended		
	Angiography, Right Ventriculography, Femoral Venography), When Performed;	Clinical Review to avoid post-service review.		
	Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber			
22217	Leadless Pacemaker System)		=///0000	40/04/0000
0801T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Pacemaker, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound,	Medical Policy Criteria. Submit for Recommended		
	Right Atrial Angiography, Right Ventriculography, Femoral Venography) And	Clinical Review to avoid post-service review.		
	Device Evaluation (Eg, Interrogation Or Programming), When Performed; Dual-			
0802T	Chamber System (Ie, Right Atrial And Right Ventricular Pacemaker Components) Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00021		Medical Policy Criteria. Submit for Recommended	1/1/2023	12/31/2999
	Right Atrial Angiography, Right Ventriculography, Femoral Venography) And	Clinical Review to avoid post-service review.		
	Device Evaluation (Eg. Interrogation Or Programming), When Performed; Right	Cliffical Review to avoid post-service review.		
	Atrial Pacemaker Component			
0803T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
00001		Medical Policy Criteria. Submit for Recommended	17172020	12/01/2000
	Right Atrial Angiography, Right Ventriculography, Femoral Venography) And	Clinical Review to avoid post-service review.		
	Device Evaluation (Eg, Interrogation Or Programming), When Performed; Right	Cirrical Neview to avoid poor service review.		
	Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless			
	Pacemaker System)			
0804T	Programming Device Evaluation (In Person) With Iterative Adjustment Of	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Implantable Device To Test The Function Of Device And To Select Optimal	Medical Policy Criteria. Submit for Recommended		
	Permanent Programmed Values, With Analysis, Review, And Report, By A	Clinical Review to avoid post-service review.		
	Physician Or Other Qualified Health Care Professional, Leadless Pacemaker	·		
	System In Dual Cardiac Chambers			
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (le,	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Caval Valve Implantation [Cavi]); Percutaneous Femoral Vein Approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0806T		MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Caval Valve Implantation [Cavi]); Open Femoral Vein Approach	Medical Policy Criteria. Submit for Recommended		
<u> </u>		Clinical Review to avoid post-service review.		

0807T	From Separately Captured Cinefluorograph Images; In Combination With Previously Acquired Computed Tomography (Ct) Images, Including Data Preparation And Transmission, Quantification Of Pulmonary Tissue Ventilation, Data Review, Interpretation And Report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0808T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Computed Tomography (Ct) Images Taken For The Purpose Of Pulmonary Tissue Ventilation Analysis, Including Data Preparation And Transmission, Quantification Of Pulmonary Tissue Ventilation, Data Review, Interpretation And Report	Not subject to pre-service review. Check EIU	7/1/2023	12/31/2999
0810T	Subretinal Injection Of A Pharmacologic Agent, Including Vitrectomy And 1 Or More Retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0811T	Remote Multi-Day Complex Uroflowmetry (Eg, Calibrated Electronic Equipment); Set-Up And Patient Education On Use Of Equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
0812T	Device Supply With Automated Report Generation, Up To 10 Days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
0813T	Esophagogastroduodenoscopy, Flexible, Transoral, With Volume Adjustment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0814T	Percutaneous Injection Of Calcium-Based Biodegradable Osteoconductive Material, Proximal Femur, Including Imaging Guidance, Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg, Array Or Leadless), And Pulse Generator Or Receiver, Including Analysis, Programming, And Imaging Guidance, When Performed, Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0817T	When Performed, Posterior Tibial Nerve; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0818T	Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
0819T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction, Including Analysis, Programming, And Imaging, When Performed, Posterior Tibial Nerve; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
0820T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis Intervention), As Needed, During Psychedelic Medication Therapy; First Physician Or Other Qualified Health Care Professional, Each Hour	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
0821T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis Intervention), As Needed, During Psychedelic Medication Therapy; Second Physician Or Other Qualified Health Care Professional, Concurrent With First Physician Or Other Qualified Health Care Professional, Each Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999

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0822T	Continuous In-Person Monitoring And Intervention (Eg, Psychotherapy, Crisis	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Intervention), As Needed, During Psychedelic Medication Therapy; Clinical Staff	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
	Concurrent With First Physician Or Other Qualified Health Care Professional, Each			
	Hour (List Separately In Addition To Code For Primary Procedure)			
0823T	Transcatheter Insertion Of Permanent Single-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	Right Atrial, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound,	Medical Policy Criteria. Submit for Recommended		
	Right Atrial Angiography And/Or Right Ventriculography, Femoral Venography,	Clinical Review to avoid post-service review.		
	Cavography) And Device Evaluation (Eg, Interrogation Or Programming), When			
	Performed			
0824T	Transcatheter Removal Of Permanent Single-Chamber Leadless Pacemaker,	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	Right Atrial, Including Imaging Guidance (Eg, Fluoroscopy, Venous Ultrasound,	Medical Policy Criteria. Submit for Recommended		
	Right Atrial Angiography And/Or Right Ventriculography, Femoral Venography,	Clinical Review to avoid post-service review.		
	Cavography), When Performed			
0825T	Transcatheter Removal And Replacement Of Permanent Single-Chamber	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		1
	Venous Ultrasound, Right Atrial Angiography And/Or Right Ventriculography,	Clinical Review to avoid post-service review.		
	Femoral Venography, Cavography) And Device Evaluation (Eg, Interrogation Or	ominati Neview to avoid poor convict review.		
	Programming), When Performed			
0826T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
00201		Medical Policy Criteria. Submit for Recommended	3/13/2024	12/31/2333
	Permanent Programmed Values With Analysis, Review And Report By A	Clinical Review to avoid post-service review.		
	Physician Or Other Qualified Health Care Professional, Leadless Pacemaker	Cililical Review to avoid post-service review.		
0857T	System In Single-Cardiac Chamber  Opto-Acoustic Imaging, Breast, Unilateral, Including Axilla When Performed, Real-	MD Cuite vie v Due en de une le en vie e une vie vere de en eine et	1/1/2024	12/31/2999
08571			1/1/2024	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
	Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.	101110001	10/04/0000
0858T		EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	Measurement Of Evoked Cortical Potentials With Automated Report	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0861T		MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Pacing; Both Components (Battery And Transmitter)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0862T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Ventricular Pacing, Including Device Interrogation And Programming; Battery	Medical Policy Criteria. Submit for Recommended		
	Component Only	Clinical Review to avoid post-service review.		
0863T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Ventricular Pacing, Including Device Interrogation And Programming; Transmitter	Medical Policy Criteria. Submit for Recommended		
	Component Only	Clinical Review to avoid post-service review.		
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum,	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
0865T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Comparison To Prior Magnetic Resonance (Mr) Study(les), Including Lesion	Medical Policy Criteria. Submit for Recommended		
	Identification, Characterization, And Quantification, With Brain Volume(S)	Clinical Review to avoid post-service review.		
	Quantification And/Or Severity Score, When Performed, Data Preparation And	Carrious to avoid poor out vice review.		
	Transmission, Interpretation And Report, Obtained Without Diagnostic Mri			
	Examination Of The Brain During The Same Session			
	Examination Of the drain Duning the Same Session			

0866T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Comparison To Prior Magnetic Resonance (Mr) Study(les), Including Lesion	Medical Policy Criteria. Submit for Recommended		
	Detection, Characterization, And Quantification, With Brain Volume(S)	Clinical Review to avoid post-service review.		
	Quantification And/Or Severity Score, When Performed, Data Preparation And	<u>'</u>		
	Transmission, Interpretation And Report, Obtained With Diagnostic Mri			
	Examination Of The Brain (List Separately In Addition To Code For Primary			
	Procedure)			
)870T	Implantation Of Subcutaneous Peritoneal Ascites Pump System, Percutaneous,	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Including Pump-Pocket Creation, Insertion Of Tunneled Indwelling Bladder And	Medical Policy Criteria. Submit for Recommended		
	Peritoneal Catheters With Pump Connections, Including All Imaging And Initial	Clinical Review to avoid post-service review.		
	Programming, When Performed	Ciminal records to a rola poor control		
)871T	Replacement Of A Subcutaneous Peritoneal Ascites Pump, Including	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Reconnection Between Pump And Indwelling Bladder And Peritoneal Catheters,	Medical Policy Criteria. Submit for Recommended		
	Including Initial Programming And Imaging, When Performed	Clinical Review to avoid post-service review.		
)872T		MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Of Catheter(S) And Connection With Previously Implanted Peritoneal Ascites	Medical Policy Criteria. Submit for Recommended		1-7-11-11-11
	Pump, Including Imaging And Programming, When Performed	Clinical Review to avoid post-service review.		
0873T	Revision Of A Subcutaneously Implanted Peritoneal Ascites Pump System, Any	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Component (Ascites Pump, Associated Peritoneal Catheter, Associated Bladder	Medical Policy Criteria. Submit for Recommended		1-7-11-11-11
	Catheter), Including Imaging And Programming, When Performed	Clinical Review to avoid post-service review.		
0874T	Removal Of A Peritoneal Ascites Pump System, Including Implanted Peritoneal	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Ascites Pump And Indwelling Bladder And Peritoneal Catheters	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0875T	Programming Of Subcutaneously Implanted Peritoneal Ascites Pump System By	MP Criteria: Procedure/service reviewed against	9/1/2024	12/31/2999
	Physician Or Other Qualified Health Care Professional	Medical Policy Criteria. Submit for Recommended		
	, ,,	Clinical Review to avoid post-service review.		
9701A	Non-Prescription Drugs	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A0021	Ambulance Service, Outside State Per Mile, Transport (Medicaid Only)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A0080	Non-Emergency Transportation, Per Mile - Vehicle Provided By Volunteer	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	(Individual Or Organization), With No Vested Interest	the Plan. Not subject to pre-service review.		
A0090	Non-Emergency Transportation, Per Mile - Vehicle Provided By Individual (Family	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Member, Self, Neighbor) With Vested Interest	the Plan. Not subject to pre-service review.		
A0100	Non-Emergency Transportation; Taxi	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A0110	Non-Emergency Transportation And Bus, Intra Or Inter State Carrier	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A0120	Non-Emergency Transportation: Mini-Bus, Mountain Area Transports, Or Other	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Transportation Systems	the Plan. Not subject to pre-service review.		
A0130	Non-Emergency Transportation: Wheel-Chair Van	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
\0140	Non-Emergency Transportation And Air Travel (Private Or Commercial) Intra Or	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Inter State	the Plan. Not subject to pre-service review.		
N0160	Non-Emergency Transportation: Per Mile - Case Worker Or Social Worker	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
\0170	Transportation Ancillary: Parking Fees, Tolls, Other	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	, , , , , ,	the Plan. Not subject to pre-service review.		
A0180	Non-Emergency Transportation: Ancillary: Lodging-Recipient	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	J , ,,gg	the Plan. Not subject to pre-service review.		

A0190	Non-Emergency Transportation: Ancillary: Meals-Recipient	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
A0200	Non-Emergency Transportation: Ancillary: Lodging Escort	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1.2.2
A0210	Non-Emergency Transportation: Ancillary: Meals-Escort	Non Covered: Procedure/service not covered by	5/3/2006	12/31/2999
	= 3,,	the Plan. Not subject to pre-service review.		1.2.2
A0420	Ambulance Waiting Time (Als Or Bls), One Half (1/2) Hour Increments	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
10.120	This did not training time (tile of bio), one than (1/2) their more more	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
A0426	Ambulance Service, Advanced Life Support, Non-Emergency Transport, Level 1	MP Criteria: Procedure/service reviewed against	9/15/2014	12/31/2999
	(Als 1)	Medical Policy Criteria. Submit for Recommended	07.0720	12/01/2000
	(* " )	Clinical Review to avoid post-service review.		
A0427	Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 (Als1-	MP Criteria: Procedure/service reviewed against	9/15/2014	12/31/2999
10421	Emergency)	Medical Policy Criteria. Submit for Recommended	0/10/2011	12/01/2000
	Emorgonoy)	Clinical Review to avoid post-service review.		
\0428	Ambulance Service, Basic Life Support, Non-Emergency Transport, (Bls)	MP Criteria: Procedure/service reviewed against	9/15/2014	12/31/2999
10420	Ambulance octyles, basic file oupport, Non-Emergency Transport, (bis)	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/01/2000
		Clinical Review to avoid post-service review.		
A0430	Ambulance Service, Conventional Air Services, Transport, One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
10430	Ambulance Service, Conventional All Services, Transport, One way (Fixed willy)	Medical Policy Criteria. Submit for Recommended	1/1/1930	12/3/1/2999
10404	Ambulance Service, Conventional Air Services, Transport, One Way (Rotary Wing)	Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
.0431	Ambulance Service, Conventional Air Services, Transport, One way (Rotary wing)		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.100		Clinical Review to avoid post-service review.	4101000	10/04/0000
\0432	Paramedic Intercept (Pi), Rural Area, Transport Furnished By A Volunteer	Non Covered: Procedure/service not covered by	4/2/2007	12/31/2999
	Ambulance Company Which Is Prohibited By State Law From Billing Third Party	the Plan. Not subject to pre-service review.		
	Payers			
A0435	Fixed Wing Air Mileage, Per Statute Mile	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
\0436	Rotary Wing Air Mileage, Per Statute Mile	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0888	Noncovered Ambulance Mileage, Per Mile (E. G., For Miles Traveled Beyond	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Closest Appropriate Facility)	the Plan. Not subject to pre-service review.		
A0998	Ambulance Response And Treatment, No Transport	MP Criteria: Procedure/service reviewed against	12/1/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2001	Innovamatrix Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2002	Mirragen Advanced Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
	· · ·	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
\2004	Xcellistem, 1 Mg	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
	7.5556, 1 1119	Not subject to pre-service review. Check EIU	., 10,2022	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
		Couling Folicy (GFGF).		

A2005	Microlyte Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2006	Novosorb Synpath Dermal Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2007	Restrata, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2008	Theragenesis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2009	Symphony, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2010	Apis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2011	Supra Sdrm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2012	Suprathel, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
A2013	Innovamatrix Fs, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
10011	0 0 11 11 12 100 11	Coding Policy (CPCP).	10/04/0000
A2014	Omeza Collagen Matrix, Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. 4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
10015	BL : W INT: B 0 0 5	Coding Policy (CPCP).	10/04/0000
A2015	Phoenix Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
10010	Down and the D. Down Owners O. 11. 1	Coding Policy (CPCP).	40/04/0222
A2016	Permeaderm B, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

A2017	Permeaderm Glove, Each	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
12017	l emeadem Glove, Lacii	Not subject to pre-service review. Check EIU	4/1/2023	12/3 1/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2018	Permeaderm C, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
2010	1 cinicadenni o, i ci oquale ochumeter	Not subject to pre-service review. Check EIU	4/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2019	Kerecis Omega3 Marigen Shield, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2020	Ac5 Advanced Wound System (Ac5)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2021	Neomatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2022	Innovaburn Or Innovamatrix XI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2023	Innovamatrix Pd, 1 Mg	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2024	Resolve Matrix Or Xenopatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
12025	Miro3D, Per Cubic Centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2026	Restrata Minimatrix, 5 Mg	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4100	Skin Substitute, Fda Cleared As A Device, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4238	Supply Allowance For Adjunctive, Non-Implanted Continuous Glucose Monitor	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
	(Cgm), Includes All Supplies And Accessories, 1 Month Supply = 1 Unit Of Service			
		Clinical Review to avoid post-service review.		
4341	Indwelling Intraurethral Drainage Device With Valve, Patient Inserted,	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	Replacement Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

A4342	Accessories For Patient Inserted Indwelling Intraurethral Drainage Device With	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	Valve, Replacement Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
N4438	Adhesive Clip Applied To The Skin To Secure External Electrical Nerve Stimulator	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Controller, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4453	Rectal Catheter For Use With The Manual Pump-Operated Enema System,	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4457	Enema Tube, With Or Without Adapter, Any Type, Replacement Only, Each	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
A4458	Enema Bag With Tubing, Reusable	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A4468	Exsufflation Belt, Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4520	Incontinence Garment, Any Type, (E.G. Brief, Diaper), Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
A4540	Distal Transcutaneous Electrical Nerve Stimulator, Stimulates Peripheral Nerves	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Of The Upper Arm	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
A4541	Monthly Supplies For Use Of Device Coded At E0733	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Peripheral Nerves Of The Wrist	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
A4553	Non-Disposable Underpads, All Sizes	Non Covered: Procedure/service not covered by	1/1/2017	12/31/2999
	7.00. 2.0p00002.0 0.100.p0000,7 til 0.1200	the Plan. Not subject to pre-service review.	., ., _ 0	12/01/2000
A4555	Electrode/Transducer For Use With Electrical Stimulation Device Used For Cancer	MP Criteria: Procedure/service reviewed against	6/15/2017	12/31/2999
11000	Treatment, Replacement Only	Medical Policy Criteria. Submit for Recommended	0/10/2011	12/01/2000
	Troution, replacement only	Clinical Review to avoid post-service review.		
A4560	Neuromuscular Electrical Stimulator (Nmes), Disposable, Replacement Only	EIU: Procedure/service not reimbursed by the Plan.	1/15/2024	12/31/2999
14000	Troutoffidodial Elocatodi Gamaiator (1411100), Biopodabio, Tropidodiffori Grify	Not subject to pre-service review. Check EIU	1710/2024	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
4373	Topical Hyperbanic Oxygen Chamber, Disposable	Not subject to pre-service review. Check EIU	12/1/2020	12/3/1/2999
		policy, which is one of our Clinical Payment and		
44595	Electrical Stimulator Supplies, 2 Lead, Per Month, (E. G. Tens, Nmes)	Coding Policy (CPCP).  Non Covered: Procedure/service not covered by	1/25/2013	12/31/2999
4393	Electrical Stiffulator Supplies, 2 Lead, Per Month, (E. G. Tens, NMes)	•	1/25/2013	12/31/2999
A 4500	Consider Floodwath and the China state of Constant Constant Constant Constant	the Plan. Not subject to pre-service review.	4/4/0000	40/04/0000
44596	Cranial Electrotherapy Stimulation (Ces) System Supplies And Accessories, Per	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
	Month	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

A4600	Sleeve For Intermittent Limb Compression Device, Replacement Only, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2008	12/31/2999
		Clinical Review to avoid post-service review.		
A4630	Replacement Batteries, Medically Necessary, Transcutaneous Electrical	Non Covered: Procedure/service not covered by	4/15/2007	12/31/2999
	Stimulator, Owned By Patient	the Plan. Not subject to pre-service review.		
A4638	Replacement Battery For Patient-Owned Ear Pulse Generator, Each	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4639	Replacement Pad For Infrared Heating Pad System, Each	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
A4660	Sphygmomanometer/Blood Pressure Apparatus With Cuff And Stethoscope	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A4663	Blood Pressure Cuff Only	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A4930	Gloves, Sterile, Per Pair	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A4931	Oral Thermometer, Reusable, Any Type, Each	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	······································	the Plan. Not subject to pre-service review.		1.2,0 1,200
A4932	Rectal Thermometer, Reusable, Any Type, Each	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	the Plan. Not subject to pre-service review.		1.2,0 1,200
A6000	Non-Contact Wound Warming Wound Cover For Use With The Non-Contact	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	Wound Warming Device And Warming Card	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
A6550	Wound Care Set, For Negative Pressure Wound Therapy Electrical Pump,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Includes All Supplies And Accessories	Medical Policy Criteria. Submit for Recommended		
	''	Clinical Review to avoid post-service review.		
A6590	External Urinary Catheters; Disposable, With Wicking Material, For Use With	Non Covered: Procedure/service not covered by	4/1/2023	12/31/2999
	Suction Pump, Per Month	the Plan. Not subject to pre-service review.		
A6591	External Urinary Catheter, Non-Disposable, For Use With Suction Pump, Per	Non Covered: Procedure/service not covered by	4/1/2023	12/31/2999
	Month	the Plan. Not subject to pre-service review.		
A7020	Interface For Cough Stimulating Device, Includes All Components, Replacement	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A7025	High Frequency Chest Wall Oscillation System Vest, Replacement For Use With	MP Criteria: Procedure/service reviewed against	1/1/2003	12/31/2999
	Patient Owned Equipment, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A7026	High Frequency Chest Wall Oscillation System Hose, Replacement For Use With	MP Criteria: Procedure/service reviewed against	1/1/2003	12/31/2999
	Patient Owned Equipment, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A7047	Oral Interface Used With Respiratory Suction Pump, Each	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A7049	Expiratory Positive Airway Pressure Intranasal Resistance Valve	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

A9150	Non-Prescription Drugs	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A9152	Single Vitamin/Mineral/Trace Element, Oral, Per Dose, Not Otherwise Specified	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
A9153	Multiple Vitamins, With Or Without Minerals And Trace Elements, Oral, Per Dose,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Not Otherwise Specified	the Plan. Not subject to pre-service review.		
A9180	Pediculosis (Lice Infestation) Treatment, Topical, For Administration By	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Patient/Caretaker	the Plan. Not subject to pre-service review.		
A9270	Non-Covered Item Or Service	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A9272	Wound Suction, Disposable, Includes Dressing, All Accessories And Components,	MP Criteria: Procedure/service reviewed against	11/1/2013	12/31/2999
	Any Type, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9273	Cold Or Hot Fluid Bottle, Ice Cap Or Collar, Heat And/Or Cold Wrap, Any Type	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
	,,,,	the Plan. Not subject to pre-service review.		1.2.0.1.2.00
A9281	Reaching/Grabbing Device, Any Type, Any Length, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
10201	Trodoming/Ordbbing Bovios, 7thy Typo, 7thy Estigui, Edon	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
A9285	Inversion/Eversion Correction Device	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
A3203	Inversion/Eversion Confection Device	Not subject to pre-service review. Check EIU	12/1/2020	12/3/1/2999
		policy, which is one of our Clinical Payment and		
10004	December 1 - Digital Committee And I/On Date of small Theorems Education of Date	Coding Policy (CPCP).	0/4/0004	40/04/0000
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy, Fda Cleared, Per	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
	Course Of Treatment	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
A9515	Choline C-11, Diagnostic, Per Study Dose Up To 20 Millicuries	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9580	Sodium Fluoride F-18, Diagnostic, Per Study Dose, Up To 30 Millicuries	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9582	Iodine I-123 Iobenguane, Diagnostic, Per Study Dose, Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against	8/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9588	Fluciclovine F-18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A9596	Gallium Ga-68 Gozetotide, Diagnostic, (Illuccix), 1 Millicurie	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		.2,0.,2000
		Clinical Review to avoid post-service review.		
A9601	Flortaucipir F 18 Injection, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
10001	Theradolphi i To Injection, Diagnostic, Tivililloune	Medical Policy Criteria. Submit for Recommended	1,1,2022	12/01/2000
A9602	Fluorodopa F-18, Diagnostic, Per Millicurie	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
49002	Fiuorodopa F-16, Diagnostic, Per Millicurie	<u> </u>	10/1/2022	12/3/1/2999
		Medical Policy Criteria. Submit for Recommended		
40000	F1 - 61 - 4 - 5 - 40 - B)	Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
A9608	Flotufolastat F 18, Diagnostic, 1 Millicurie	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		ĺ

A9609	Fludeoxyglucose F18 Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
A9800	Gallium Ga-68 Gozetotide, Diagnostic, (Locametz), 1 Millicurie	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
B4102	Enteral Formula, For Adults, Used To Replace Fluids And Electrolytes (E.G. Clear Liquids), 500 MI = 1 Unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4103	Enteral Formula, For Pediatrics, Used To Replace Fluids And Electrolytes (E.G. Clear Liquids), 500 MI = 1 Unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4104	Additive For Enteral Formula (E.G. Fiber)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
34105	In-Line Cartridge Containing Digestive Enzyme(S) For Enteral Feeding, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
B4149	Enteral Formula, Manufactured Blenderized Natural Foods With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
34150	Enteral Formula, Nutritionally Complete With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
34152	Enteral Formula, Nutritionally Complete, Calorically Dense (Equal To Or Greater Than 1. 5 Kcal/MI) With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
34153	Enteral Formula, Nutritionally Complete, Hydrolyzed Proteins (Amino Acids And Peptide Chain), Includes Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
34154	Enteral Formula, Nutritionally Complete, For Special Metabolic Needs, Excludes Inherited Disease Of Metabolism, Includes Altered Composition Of Proteins, Fats, Carbohydrates, Vitamins And/Or Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
34155	Enteral Formula, Nutritionally Incomplete/Modular Nutrients, Includes Specific Nutrients, Carbohydrates (E. G. Glucose Polymers), Proteins/Amino Acids (E. G. Glutamine, Arginine), Fat (E. G. Medium Chain Triglycerides) Or Combination, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
34157	Enteral Formula, Nutritionally Complete, For Special Metabolic Needs For Inherited Disease Of Metabolism, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
34158	Enteral Formula, For Pediatrics, Nutritionally Complete With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber And/Or Iron, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
B4159	Enteral Formula, For Pediatrics, Nutritionally Complete Soy Based With Intact Nutrients, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber And/Or Iron, Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999

34160	Enteral Formula, For Pediatrics, Nutritionally Complete Calorically Dense (Equal	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	To Or Greater Than 0.7 Kcal/MI) With Intact Nutrients, Includes Proteins, Fats,	Medical Policy Criteria. Submit for Recommended		
	Carbohydrates, Vitamins And Minerals, May Include Fiber, Administered Through	Clinical Review to avoid post-service review.		
	An Enteral Feeding Tube, 100 Calories = 1 Unit			
161	Enteral Formula, For Pediatrics, Hydrolyzed/Amino Acids And Peptide Chain	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Proteins, Includes Fats, Carbohydrates, Vitamins And Minerals, May Include Fiber,	Medical Policy Criteria. Submit for Recommended		
	Administered Through An Enteral Feeding Tube, 100 Calories = 1 Unit	Clinical Review to avoid post-service review.		
162	Enteral Formula, For Pediatrics, Special Metabolic Needs For Inherited Disease Of	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	Metabolism, Includes Proteins, Fats, Carbohydrates, Vitamins And Minerals, May	Medical Policy Criteria. Submit for Recommended		
	Include Fiber, Administered Through An Enteral Feeding Tube, 100 Calories = 1	Clinical Review to avoid post-service review.		
	Unit	· ·		
164	Parenteral Nutrition Solution: Carbohydrates (Dextrose), 50% Or Less (500 MI = 1	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Unit) - Homemix	Medical Policy Criteria. Submit for Recommended		
	· ,	Clinical Review to avoid post-service review.		
168	Parenteral Nutrition Solution; Amino Acid, 3. 5%, (500 MI = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
172	Parenteral Nutrition Solution; Amino Acid, 5. 5% Through 7%, (500 MI = 1 Unit) -	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
· · =	Homemix	Medical Policy Criteria. Submit for Recommended		, .,,
	Homomix	Clinical Review to avoid post-service review.		
176	Parenteral Nutrition Solution; Amino Acid, 7% Through 8. 5%, (500 MI = 1 Unit) -	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
170	Homemix	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	Homemix	Clinical Review to avoid post-service review.		
178	Parenteral Nutrition Solution: Amino Acid, Greater Than 8. 5% (500 Ml = 1 Unit) -	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
170	Homemix	Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
	nomemix	Clinical Review to avoid post-service review.		
180	Parenteral Nutrition Solution; Carbohydrates (Dextrose), Greater Than 50% (500	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
100	MI=1 Unit) - Homemix		1/21/2009	12/31/2999
	IVII— I Offic) - nomernix	Medical Policy Criteria. Submit for Recommended		
185	Parenteral Nutrition Solution, Not Otherwise Specified, 10 Grams Lipids	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
100	Parenteral Nutrition Solution, Not Otherwise Specified, 10 Grams Lipids	•	1/21/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
400	Department Nutrition Colutions Communicated America Acid And Control and Alith	Clinical Review to avoid post-service review.	7/07/0000	12/31/2999
193	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
10-	52 To 73 Grams Of Protein - Premix	Clinical Review to avoid post-service review.	7/07/0000	40/04/0000
197	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
100	74 To 100 Grams Of Protein - Premix	Clinical Review to avoid post-service review.	7/07/0000	10/01/0000
199	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
	Over 100 Grams Of Protein - Premix	Clinical Review to avoid post-service review.		101011000
216	Parenteral Nutrition; Additives (Vitamins, Trace Elements, Heparin, Electrolytes)	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Homemix Per Day	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
220	Parenteral Nutrition Supply Kit; Premix, Per Day	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
222	Parenteral Nutrition Supply Kit; Home Mix, Per Day	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	I	

B4224	Parenteral Nutrition Administration Kit, Per Day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/27/2009	12/31/2999
		Clinical Review to avoid post-service review.		
B5000	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
	Renal-Aminosyn-Rf, Nephramine, Renamine-Premix	Clinical Review to avoid post-service review.		
35100	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
	Hepatic, Hepatamine-Premix	Clinical Review to avoid post-service review.		
35200	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Electrolytes, Trace Elements, And Vitamins, Including Preparation, Any Strength,	Medical Policy Criteria. Submit for Recommended		
	Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix	Clinical Review to avoid post-service review.		
39004	Parenteral Nutrition Infusion Pump, Portable	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
B9006	Parenteral Nutrition Infusion Pump, Stationary	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	,,	Medical Policy Criteria. Submit for Recommended	.,_,,_,	1.2,0 %,200
		Clinical Review to avoid post-service review.		
C1052	Hemostatic Agent, Gastrointestinal, Topical	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
31002	Tromostatio Agont, Gastionnostinai, Topicai	Not subject to pre-service review. Check EIU	0/10/2021	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
C1062	Intravertebral Body Fracture Augmentation With Implant (E.G., Metal, Polymer)	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
71002	Intravertebral Body Fractale Adgineritation With Implant (E.S., Wetai, Folymer)	Medical Policy Criteria. Submit for Recommended	7/1/2021	12/01/2000
		Clinical Review to avoid post-service review.		
C1600	Catheter, Transluminal Intravascular Lesion Preparation Device, Bladed, Sheathed	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
01000	(Insertable)	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/01/2000
	(moertable)	Clinical Review to avoid post-service review.		
C1605	Pacemaker, Leadless, Dual Chamber (Right Atrial And Right Ventricular	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
51005		Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
	For Implantation	Clinical Review to avoid post-service review.		
C1726	Cath, Bal Dil, Non-Vascular	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
51720	Catil, Dai Dii, Noii-Vasculai	_	0/3/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
C1761	Catheter, Transluminal Intravascular Lithotripsy, Coronary	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
51/01	Catheter, Transiuminal Intravascular Lithotripsy, Coronary		7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
24704	Front December Oscillar	Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
C1764	Event Recorder, Cardiac	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
2.1=2=		Clinical Review to avoid post-service review.	0/5/00/0	10/01/0000
C1767	Generator, Neurostimulator (Implantable), Non-Rechargeable	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1778	Lead, Neurostimulator	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

C1783	Ocular Implant, Aqueous Drainage Assist Device	MP Criteria: Procedure/service reviewed against	3/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1787	Patient Progr, Neurostim	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1816	Receiver/Transmitter, Neuro	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1817	Septal Defect Imp Sys	MP Criteria: Procedure/service reviewed against	4/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1820	Generator, Neurostimulator (Implantable), With Rechargeable Battery And	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
	Charging System	Medical Policy Criteria. Submit for Recommended		
	Jgg	Clinical Review to avoid post-service review.		
C1821	Interspinous Process Distraction Device (Implantable)	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
0.02.	(pia.iiasis)	Medical Policy Criteria. Submit for Recommended	,,	12/01/2000
		Clinical Review to avoid post-service review.		
C1822	Generator, Neurostimulator (Implantable), High Frequency, With Rechargeable	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
0.1022	Battery And Charging System	Medical Policy Criteria. Submit for Recommended	1710/2020	12/01/2000
	Buttory 7 tha Orlanging Cystom	Clinical Review to avoid post-service review.		
C1823	Generator, Neurostimulator (Implantable), Non-Rechargeable, With Transvenous	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
01020	Sensing And Stimulation Leads	Not subject to pre-service review. Check EIU	7/1/2022	12/01/2000
	Conting 7 and Carmanation Ecodo	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
C1824	Generator, Cardiac Contractility Modulation (Implantable)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
01024	Certerator, Gardiae Contractinty Modulation (Implantable)	Medical Policy Criteria. Submit for Recommended	0/10/2024	12/01/2000
		Clinical Review to avoid post-service review.		
C1825	Generator, Neurostimulator (Implantable), Non-Rechargeable With Carotid Sinus	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
01023	Baroreceptor Stimulation Lead(S)	Medical Policy Criteria. Submit for Recommended	2/1/2021	12/31/2999
	Baloreceptor Stimulation Lead(S)	Clinical Review to avoid post-service review.		
C1826	Generator, Neurostimulator (Implantable), Includes Closed Feedback Loop Leads	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
C 1020	And All Implantable Components, With Rechargeable Battery And Charging	Medical Policy Criteria. Submit for Recommended	111/2025	12/31/2999
	System	Clinical Review to avoid post-service review.		
C1827	Generator, Neurostimulator (Implantable), Non-Rechargeable, With Implantable	EIU: Procedure/service not reimbursed by the Plan.	0/1/2023	12/31/2999
01021	Stimulation Lead And External Paired Stimulation Controller	Not subject to pre-service review. Check EIU	9/1/2023	12/31/2999
	Stillidation Lead And External Palled Stillidation Controller	policy, which is one of our Clinical Payment and		
C1831	Interbody Cage, Anterior, Lateral Or Posterior, Personalized (Implantable)	Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
J 100 I	Interbody Cage, Anterior, Lateral Or Posterior, Personalized (Implantable)		10/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
04000	Automoft Cuspanies Instudies Call Describes And Application A LANC.	Clinical Review to avoid post-service review.	E/4E/0004	40/04/0000
C1832	Autograft Suspension, Including Cell Processing And Application, And All System	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Components	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

C1833	Monitor, Cardiac, Including Intracardiac Lead And All System Components (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
		Clinical Review to avoid post-service review.		
C1883	Adapt/Ext, Pacing/Neuro Lead	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2614	Probe, Percutaneous Lumbar Discectomy	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2616	Brachytx Source, Yttrium-90 "Non-Stranded"	MP Criteria: Procedure/service reviewed against	5/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2623	Catheter, Transluminal Angioplasty, Drug-Coated, Non-Laser	MP Criteria: Procedure/service reviewed against	12/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2624	Implantable Wireless Pulmonary Artery Pressure Sensor With Delivery Catheter,	MP Criteria: Procedure/service reviewed against	12/1/2019	12/31/2999
	Including All System Components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C5271	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C5272	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area,	Medical Policy Criteria. Submit for Recommended		
	Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	Clinical Review to avoid post-service review.		
C5273		MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound	Medical Policy Criteria. Submit for Recommended		
	Surface Area, Or 1% Of Body Area Of Infants And Children	Clinical Review to avoid post-service review.		
C5274	Application Of Low Cost Skin Substitute Graft To Trunk, Arms, Legs, Total Wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm	Medical Policy Criteria. Submit for Recommended		
	Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of	Clinical Review to avoid post-service review.		
	Infants And Children, Or Part Thereof (List Separately In Addition To Code For	·		
	Primary Procedure)			
C5275	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound	Medical Policy Criteria. Submit for Recommended		
	Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	Clinical Review to avoid post-service review.		
C5276	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound	Medical Policy Criteria. Submit for Recommended		
	Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area,	Clinical Review to avoid post-service review.	1	
	Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	·		
C5277	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound	Medical Policy Criteria. Submit for Recommended	1	
	Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound	Clinical Review to avoid post-service review.		
	Surface Area, Or 1% Of Body Area Of Infants And Children			

C5278	Application Of Low Cost Skin Substitute Graft To Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits, Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area, Or Part Thereof, Or Each Additional 1% Of Body Area Of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
	Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)			
C9354	Acellular Pericardial Tissue Matrix Of Non-Human Origin (Veritas), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9356	Tendon, Porous Matrix Of Cross-Linked Collagen And Glycosaminoglycan Matrix (Tenoglide Tendon Protector Sheet), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9358	Dermal Substitute, Native, Non-Denatured Collagen, Fetal Bovine Origin (Surgimend Collagen Matrix), Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9360	Dermal Substitute, Native, Non-Denatured Collagen, Neonatal Bovine Origin (Surgimend Collagen Matrix), Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9363	Skin Substitute, Integra Meshed Bilayer Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C9364	Porcine Implant, Permacol, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9734	Focused Ultrasound Ablation/Therapeutic Intervention, Other Than Uterine Leiomyomata, With Magnetic Resonance (Mr) Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2014	12/31/2999
C9739	Cystourethroscopy, With Insertion Of Transprostatic Implant; 1 To 3 Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9740	Cystourethroscopy, With Insertion Of Transprostatic Implant; 4 Or More Implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9757	Laminotomy (Hemilaminectomy), With Decompression Of Nerve Root(S), Including Partial Facetectomy, Foraminotomy And Excision Of Herniated Intervertebral Disc, And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Closure Device, Including Annular Defect Measurement, Alignment And Sizing Assessment, And Image Guidance; 1 Interspace, Lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9764	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, Includes Angioplasty Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9765	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With Intravascular Lithotripsy, And Transluminal Stent Placement(S), Includes Angioplastyš Within The Same Vessel(S), When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999

C9766	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
	Vessel(S), When Performed	Clinical Review to avoid post-service review.		
9767	Revascularization, Endovascular, Open Or Percutaneous, Any Vessel(S); With	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	Intravascular Lithotripsy And Transluminal Stent Placement(S), And Atherectomy,	Medical Policy Criteria. Submit for Recommended		
	Includes Angioplasty Within The Same Vessel(S), When Performed	Clinical Review to avoid post-service review.		
9768	Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic	EIU: Procedure/service not reimbursed by the Plan.	3/1/2021	12/31/2999
	Pressure Gradient By Any Method (List Separately In Addition To Code For	Not subject to pre-service review. Check EIU		
	Primary Procedure)	policy, which is one of our Clinical Payment and		
	, , , , , , , , , , , , , , , , , , , ,	Coding Policy (CPCP).		
09769	Cystourethroscopy, With Insertion Of Temporary Prostatic Implant/Stent With	MP Criteria: Procedure/service reviewed against	10/15/2020	12/31/2999
	Fixation/Anchor And Incisional Struts	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9772	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	Artery(les), With Intravascular Lithotripsy, Includes Angioplasty Within The Same	Not subject to pre-service review. Check EIU		
	Vessel (S), When Performed	policy, which is one of our Clinical Payment and		
	Vocasi (o), vinon i circinica	Coding Policy (CPCP).		
C9773	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	Artery(les); With Intravascular Lithotripsy, And Transluminal Stent Placement(S),	Not subject to pre-service review. Check EIU	07.07202.	.2,0.,2000
	Includes Angioplasty Within The Same Vessel(S), When Performed	policy, which is one of our Clinical Payment and		
	Iniciades Angiopiasty Within The Game Vessei(O), When I chomica	Coding Policy (CPCP).		
09774	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
20114	Artery(les); With Intravascular Lithotripsy And Atherectomy, Includes Angioplasty	Not subject to pre-service review. Check EIU	0/10/2021	12/01/2000
	Within The Same Vessel (S), When Performed	policy, which is one of our Clinical Payment and		
	within the dame vesser (o), when tendined	Coding Policy (CPCP).		
C9775	Revascularization, Endovascular, Open Or Percutaneous, Tibial/Peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
59115	Artery(les); With Intravascular Lithotripsy And Transluminal Stent Placement(S),	Not subject to pre-service review. Check EIU	0/13/2021	12/31/2999
	And Atherectomy, Includes Angioplasty Within The Same Vessel (S), When	policy, which is one of our Clinical Payment and		
	Performed	Coding Policy (CPCP).		
C9777	Esophageal Mucosal Integrity Testing By Electrical Impedance, Transoral,	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
50111	Includes Esophagoscopy Or Esophagogastroduodenoscopy	Not subject to pre-service review. Check EIU	0/10/2021	12/01/2000
	Initiated Esophagoscopy of Esophagogastroadoanioscopy	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
09780	Insertion Of Central Venous Catheter Through Central Venous Occlusion Via	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
30700	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended	10/1/2021	12/01/2000
	Guidance	Clinical Review to avoid post-service review.		
09782	Blinded Procedure For New York Heart Association (Nyha) Class Ii Or Iii Heart	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
, o. o. c	Failure, Or Canadian Cardiovascular Society (Ccs) Class Iii Or Iv Chronic	Medical Policy Criteria. Submit for Recommended	27 17202 1	12/01/2000
	Refractory Angina; Transcatheter Intramyocardial Transplantation Of Autologous	Clinical Review to avoid post-service review.		
	Bone Marrow Cells (E.G., Mononuclear) Or Placebo Control, Autologous Bone	Official Neview to avoid post-service review.		
	Marrow Harvesting And Preparation For Transplantation, Left Heart			
	Catheterization Including Ventriculography, All Laboratory Services, And All			
	Imaging With Or Without Guidance (E.G., Transthoracic Echocardiography,			
	Ultrasound, Fluoroscopy), Performed In An Approved Investigational Device			
20704	Exemption (Ide) Study	Fills Dropodure loom income trainshure and but the Diere	10/1/2002	12/21/2000
9784	Gastric Restrictive Procedure, Endoscopic Sleeve Gastroplasty, With	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
	Esophagogastroduodenoscopy And Intraluminal Tube Insertion, If Performed,	Not subject to pre-service review. Check EIU		
	Including All System And Tissue Anchoring Components	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

C9785	Endoscopic Outlet Reduction, Gastric Pouch Application, With Endoscopy And Intraluminal Tube Insertion, If Performed, Including All System And Tissue	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU	12/1/2023	12/31/2999
	Anchoring Components	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
9786	Echocardiography Image Post Processing For Computer Aided Detection Of Heart Failure With Preserved Ejection Fraction, Including Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
9793	3D Predictive Model Generation For Pre-Planning Of A Cardiac Procedure, Using Data From Cardiac Computed Tomographic Angiography With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
9794	Therapeutic Radiology Simulation-Aided Field Setting; Complex, Including Acquisition Of Pet And Ct Imaging Data Required For Radiopharmaceutical-Directed Radiation Therapy Treatment Planning (I.E., Modeling)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
9795	Stereotactic Body Radiation Therapy, Treatment Delivery, Per Fraction To 1 Or More Lesions, Including Image Guidance And Real-Time Positron Emissions-Based Delivery Adjustments To 1 Or More Lesions, Entire Course Not To Exceed 5 Fractions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G., Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
00372	Intraoral Tomosynthesis ? Comprehensive Series Of Radiographic Images	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0373	Intraoral Tomosynthesis ? Bitewing Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0374	Intraoral Tomosynthesis ? Periapical Radiographic Image	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0387	Intraoral Tomosynthesis ? Comprehensive Series Of Radiographic Images - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0388	Intraoral Tomosynthesis ? Bitewing Radiographic Image - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0389	Intraoral Tomosynthesis ? Periapical Radiographic Image - Image Capture Only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0396	3D Printing Of A 3D Dental Surface Scan	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
0801	3D Dental Surface Scan ? Direct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0802	3D Dental Surface Scan ? Indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0803	3D Facial Surface Scan ? Direct	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
0804	3D Facial Surface Scan ? Indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
1301	Immunization Counseling	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
1705	Astrazeneca Covid-19 Vaccine Administration ? First Dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2021	12/31/2999
1706	Astrazeneca Covid-19 Vaccine Administration ? Second Dose	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/15/2021	12/31/2999

D2989	Excavation Of A Tooth Resulting In The Determination Of Non-Restorability	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
D2991	And the stime Of the decrease stite Decrease stime Madicional Decreases	the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
D2991	Application Of Hydroxyapatite Regeneration Medicament - Per Tooth	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
D6105	Demonstrat Of Institute Desks Net Demonstrate Demonstrate Demonstrate	the Plan. Not subject to pre-service review.	1/1/2023	40/04/0000
J6105	Removal Of Implant Body Not Requiring Bone Removal Nor Flap Elevation	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
2010-		the Plan. Not subject to pre-service review.	4/4/0000	10/01/0000
D6197	Replacement Of Restorative Material Used To Close An Access Opening Of A	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Screw-Retained Implant Supported Prosthesis, Per Implant	the Plan. Not subject to pre-service review.		
D7939	Indexing For Osteotomy Using Dynamic Robotic Assisted Or Dynamic Navigation	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
D9938	Fabrication Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
D9939	Placement Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
D9954	Fabrication And Delivery Of Oral Appliance Therapy (Oat) Morning Repositioning	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
D9955	Oral Appliance Therapy (Oat) Titration Visit	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
D9956	Administration Of Home Sleep Apnea Test	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
30000	Administration of Florid Gloop Aprica Foot	Medical Policy Criteria. Submit for Recommended	17 172024	12/01/2000
		Clinical Review to avoid post-service review.		
D9957	Screening For Sleep Related Breathing Disorders	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
D9931	Screening For Steep Netated Dreathing Disorders	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
E0152	Walker, Battery Powered, Wheeled, Folding, Adjustable Or Fixed Height	Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0152	walker, Ballery Powered, Wheeled, Folding, Adjustable Or Fixed Height	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
=======================================		Clinical Review to avoid post-service review.	7/07/0000	10/01/0000
E0181	Powered Pressure Reducing Mattress Overlay/Pad, Alternating, With Pump,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Includes Heavy Duty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0182	Pump For Alternating Pressure Pad, For Replacement Only	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0183	Powered Pressure Reducing Underlay/Pad, Alternating, With Pump, Includes	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	Heavy Duty	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0184	Dry Pressure Mattress	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0185	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length And Width	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	2. 2. 2. 2. 2. 2	Medical Policy Criteria. Submit for Recommended	1.2.,2300	, ,
		Clinical Review to avoid post-service review.		
E0186	Air Pressure Mattress	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
L0100	MILL TOSSUIC MALLICSS	Medical Policy Criteria. Submit for Recommended	112112009	1210112333
	I	Clinical Review to avoid post-service review.		

E0187	Water Pressure Mattress	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0190	Positioning Cushion/Pillow/Wedge, Any Shape Or Size, Includes All Components	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	And Accessories	the Plan. Not subject to pre-service review.		
E0193	Powered Air Flotation Bed (Low Air Loss Therapy)	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0194	Air Fluidized Bed	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0196	Gel Pressure Mattress	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0217	Water Circulating Heat Pad With Pump	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0218	Fluid Circulating Cold Pad With Pump, Any Type	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	, ,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0225	Hydrocollator Unit, Includes Pads	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0231	Non-Contact Wound Warming Device (Temperature Control Unit, Ac Adapter And	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Power Cord) For Use With Warming Card And Wound Cover	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0232	Warming Card For Use With The Non Contact Wound Warming Device And Non	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Contact Wound Warming Wound Cover	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0236	Pump For Water Circulating Pad	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0239	Hydrocollator Unit, Portable	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0240	Bath/Shower Chair, With Or Without Wheels, Any Size	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0241	Bath Tub Wall Rail, Each	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0242	Bath Tub Rail, Floor Base	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0243	Toilet Rail, Each	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		

E0244	Raised Toilet Seat	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
E0247	Transfer Bench For Tub Or Toilet With Or Without Commode Opening	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
	Trailorer Boneri or Trail or Trailorer Commons of Politics	the Plan. Not subject to pre-service review.	0, 10, 202 .	.2/01/2000
E0248	Transfer Bench, Heavy Duty, For Tub Or Toilet With Or Without Commode	Non Covered: Procedure/service not covered by	5/15/2021	12/31/2999
	Opening	the Plan. Not subject to pre-service review.	0, 10, 2021	12/01/2000
E0249	Pad For Water Circulating Heat Unit, For Replacement Only	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	The state of the s	Medical Policy Criteria. Submit for Recommended	0, 1,2020	.2/01/2000
		Clinical Review to avoid post-service review.		
E0250	Hospital Bed, Fixed Height, With Any Type Side Rails, With Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
L0230	Trospital Bod, Fixed Fieight, With Arry Type Olde Italis, With Mattices	Medical Policy Criteria. Submit for Recommended	5/15/2014	12/31/2333
E0251	Hospital Bed, Fixed Height, With Any Type Side Rails, Without Mattress	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
EUZ3 I	Thospital bed, Fixed Height, with Arry Type Side Rails, Without Mattress	_	3/13/2014	12/3/1/2999
		Medical Policy Criteria. Submit for Recommended		
E0055	11	Clinical Review to avoid post-service review.	5/45/0044	40/04/0000
E0255	Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, With Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0256	Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, Without Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0260	Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Rails, With Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0261	Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Rails, Without Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0265	Hospital Bed, Total Electric (Head, Foot And Height Adjustments), With Any Type	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Side Rails, With Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0266	Hospital Bed, Total Electric (Head, Foot And Height Adjustments), With Any Type	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Side Rails. Without Mattress	Medical Policy Criteria. Submit for Recommended		
	ota (talis, matter)	Clinical Review to avoid post-service review.		
E0270	Hospital Bed, Institutional Type Includes: Oscillating, Circulating And Stryker	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Frame, With Mattress	Medical Policy Criteria. Submit for Recommended	0, 1,2020	1270172000
	Trains, that materious	Clinical Review to avoid post-service review.		
E0271	Mattress, Innerspring	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	maa soo, minoropining	Medical Policy Criteria. Submit for Recommended	., 10,2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0272	Mattress, Foam Rubber	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Iviatioss, Fualification	S S	7/13/2000	12/3/1/2999
		Medical Policy Criteria. Submit for Recommended		
E0070	Dad Daged	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
E0273	Bed Board	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	1	Clinical Review to avoid post-service review.	1	I

E0274	Over-Bed Table	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0277	Powered Pressure-Reducing Air Mattress	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0280	Bed Cradle, Any Type	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0290	Hospital Bed, Fixed Height, Without Side Rails, With Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0291	Hospital Bed, Fixed Height, Without Side Rails, Without Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0292	Hospital Bed, Variable Height, Hi-Lo, Without Side Rails, With Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0293	Hospital Bed, Variable Height, Hi-Lo, Without Side Rails, Without Mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0294	Hospital Bed, Semi-Electric (Head And Foot Adjustment), Without Side Rails, With	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0295	Hospital Bed, Semi-Electric (Head And Foot Adjustment), Without Side Rails,	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Without Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0296	Hospital Bed, Total Electric (Head, Foot And Height Adjustments). Without Side	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Rails, With Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0297	Hospital Bed, Total Electric (Head, Foot And Height Adjustments), Without Side	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Rails, Without Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0300	Pediatric Crib, Hospital Grade, Fully Enclosed, With Or Without Top Enclosure	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0301	Hospital Bed, Heavy Duty, Extra Wide, With Weight Capacity Greater Than 350	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	Pounds, But Less Than Or Equal To 600 Pounds, With Any Type Side Rails,	Medical Policy Criteria. Submit for Recommended		
	Without Mattress	Clinical Review to avoid post-service review.		
E0302	Hospital Bed, Extra Heavy Duty, Extra Wide, With Weight Capacity Greater Than	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	600 Pounds, With Any Type Side Rails, Without Mattress	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0303	Hospital Bed, Heavy Duty, Extra Wide, With Weight Capacity Greater Than 350	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Mattress	Clinical Review to avoid post-service review.		
E0304	Hospital Bed, Extra Heavy Duty, Extra Wide, With Weight Capacity Greater Than	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	600 Pounds, With Any Type Side Rails, With Mattress	Medical Policy Criteria. Submit for Recommended		
	, , , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.	1	1

E0305	Bed Side Rails, Half Length	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0310	Bed Side Rails, Full Length	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0315	Bed Accessory: Board, Table, Or Support Device, Any Type	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0316	Safety Enclosure Frame/Canopy For Use With Hospital Bed, Any Type	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0328	Hospital Bed, Pediatric, Manual, 360 Degree Side Enclosures, Top Of Headboard,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0329	Hospital Bed, Pediatric, Electric Or Semi-Electric, 360 Degree Side Enclosures,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0373	Nonpowered Advanced Pressure Reducing Mattress	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0468	Home Ventilator, Dual-Function Respiratory Device, Also Performs Additional	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Function Of Cough Stimulation, Includes All Accessories, Components And	Medical Policy Criteria. Submit for Recommended		
	Supplies For All Functions	Clinical Review to avoid post-service review.		
E0471	Respiratory Assist Device, Bi-Level Pressure Capability, With Back-Up Rate	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	Feature, Used With Noninvasive Interface, E. G., Nasal Or Facial Mask	Medical Policy Criteria. Submit for Recommended	., .,	
	(Intermittent Assist Device With Continuous Positive Airway Pressure Device)	Clinical Review to avoid post-service review.		
E0481	Intrapulmonary Percussive Ventilation System And Related Accessories	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0482	Cough Stimulating Device, Alternating Positive And Negative Airway Pressure	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
E0483	High Frequency Chest Wall Oscillation System, With Full Anterior And/Or	MP Criteria: Procedure/service reviewed against	1/1/2003	12/31/2999
20100	Posterior Thoracic Region Receiving Simultaneous External Oscillation, Includes	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	All Accessories And Supplies, Each	Clinical Review to avoid post-service review.		
E0484	Oscillatory Positive Expiratory Pressure Device, Non-Electric, Any Type, Each	MP Criteria: Procedure/service reviewed against	1/1/2003	12/31/2999
_0-10-1	Coolinatory 1 Control Expiratory 1 1000ard Dovido, 14011 Electric, 7411y 1990, Each	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
		Clinical Review to avoid post-service review.		
E0485	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Adjustable Or	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
_0-100	Non-Adjustable, Prefabricated, Includes Fitting And Adjustment	Medical Policy Criteria. Submit for Recommended	1,1,2022	12/01/2000
	Non-Adjustable, Freiabhoateu, includes Fitting And Adjustinent	Clinical Review to avoid post-service review.		
E0486	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility, Adjustable Or	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
_0+00	Non-Adjustable, Custom Fabricated, Includes Fitting And Adjustment	Medical Policy Criteria. Submit for Recommended	11112022	12/3/1/2999
	Inon-Aujustanie, Gustom i annoateu, includes Filling And Aujustinent	1		
E0487	Spirameter Floetrania Includes All Assessaries	Clinical Review to avoid post-service review.	12/15/2014	12/31/2999
10407	Spirometer, Electronic, Includes All Accessories	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

E0490	Power Source And Control Electronics Unit For Oral Device/Appliance For	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU	10/1/2023	12/31/2999
	Neuromuscular Electrical Stimulation Of The Tongue Muscle, Controlled By Hardware Remote	policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
E0491	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		12.01.200
	Controlled By Hardware Remote, 90-Day Supply	policy, which is one of our Clinical Payment and		
	Controlled by Hardware Hornest, so buy capply	Coding Policy (CPCP).		
E0492	Power Source And Control Electronics Unit For Oral Device/Appliance For	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Neuromuscular Electrical Stimulation Of The Tongue Muscle, Controlled By Phone	Medical Policy Criteria. Submit for Recommended		
	Application	Clinical Review to avoid post-service review.		
E0493	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Muscle, Used In Conjunction With The Power Source And Control Electronics Unit,	Medical Policy Criteria. Submit for Recommended		
	Controlled By Phone Application, 90-Day Supply	Clinical Review to avoid post-service review.		
E0530	Electronic Positional Obstructive Sleep Apnea Treatment, With Sensor, Includes	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	All Components And Accessories, Any Type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0616	Implantable Cardiac Event Recorder With Memory, Activator And Programmer	MP Criteria: Procedure/service reviewed against	6/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0617	External Defibrillator With Integrated Electrocardiogram Analysis	MP Criteria: Procedure/service reviewed against	12/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0618	Apnea Monitor, Without Recording Feature	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0619	Apnea Monitor, With Recording Feature	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0620	Skin Piercing Device For Collection Of Capillary Blood, Laser, Each	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		12.01.200
E0625	Patient Lift, Bathroom Or Toilet, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against	2/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0627	Seat Lift Mechanism, Electric, Any Type	MP Criteria: Procedure/service reviewed against	2/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended	2, . 0, 20 . 0	.2/01/2000
		Clinical Review to avoid post-service review.		
E0629	Seat Lift Mechanism, Non-Electric, Any Type	MP Criteria: Procedure/service reviewed against	2/15/2010	12/31/2999
20020	Court Elit Mooritamoni, Non Elocato, 7 my 1 ypo	Medical Policy Criteria. Submit for Recommended	2, 10,2010	12/01/2000
		Clinical Review to avoid post-service review.		
E0635	Patient Lift, Electric With Seat Or Sling	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
_0000	T datative Entry Encounter With Four Or Onling	Medical Policy Criteria. Submit for Recommended	5, 1,2020	12/01/2000
		Clinical Review to avoid post-service review.		
E0636	Multipositional Patient Support System, With Integrated Lift, Patient Accessible	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
L0000	Controls	Medical Policy Criteria. Submit for Recommended	5/24/2012	12/3/1/2333
	Controls	Clinical Review to avoid post-service review.		
E0637	Combination Sit To Stand Frame/Table System, Any Size Including Pediatric, With	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
EUU3/			1/1/2004	12/31/2999
	Seat Lift Feature, With Or Without Wheels	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E0638	Standing Frame/Table System, One Position (E.G. Upright, Supine Or Prone Stander), Any Size Including Pediatric, With Or Without Wheels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2004	12/31/2999
		Clinical Review to avoid post-service review.		
E0639	Patient Lift, Moveable From Room To Room With Disassembly And Reassembly,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Includes All Components/Accessories	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0640	Patient Lift, Fixed System, Includes All Components/Accessories	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0641	Standing Frame/Table System, Multi-Position (E.G. Three-Way Stander), Any Size		1/1/2006	12/31/2999
	Including Pediatric, With Or Without Wheels	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0642	Standing Frame/Table System, Mobile (Dynamic Stander), Any Size Including	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Pediatric	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0650	Pneumatic Compressor, Non-Segmental Home Model	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0651	Pneumatic Compressor, Segmental Home Model Without Calibrated Gradient	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	Pressure	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0652	Pneumatic Compressor, Segmental Home Model With Calibrated Gradient	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Pressure	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0655	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	Arm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0656	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Trunk	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0657	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Chest	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0660	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	Leg	Medical Policy Criteria. Submit for Recommended		
	9	Clinical Review to avoid post-service review.		
E0665	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	Arm	Medical Policy Criteria. Submit for Recommended		1-70 17-200
		Clinical Review to avoid post-service review.		
E0666	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	Leg	Medical Policy Criteria. Submit for Recommended		12/0//2000
		Clinical Review to avoid post-service review.		
E0667	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Leg	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
	2-3ordar roamado repilarios i si oso vitari risamado compressor, i di Esg	Medical Policy Criteria. Submit for Recommended	1,1,2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0668	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Full Arm	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
L0000	Tooghieritai i neumatic Appliance i oi Ose With Friedmatic Compressor, Full Alli	Medical Policy Criteria. Submit for Recommended	1/1/2000	12/3/1/2333
		Clinical Review to avoid post-service review.		
	<u>_</u>	Cililical Review to avoid post-service review.		

E0669	Segmental Pneumatic Appliance For Use With Pneumatic Compressor, Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2008	12/31/2999
		Clinical Review to avoid post-service review.		
E0670	Segmental Pneumatic Appliance For Use With Pneumatic Compressor,	MP Criteria: Procedure/service reviewed against	7/15/2015	12/31/2999
	Integrated, 2 Full Legs And Trunk	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0671	Segmental Gradient Pressure Pneumatic Appliance, Full Leg	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0672	Segmental Gradient Pressure Pneumatic Appliance, Full Arm	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0673	Segmental Gradient Pressure Pneumatic Appliance, Half Leg	MP Criteria: Procedure/service reviewed against	7/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0675	Pneumatic Compression Device, High Pressure, Rapid Inflation/Deflation Cycle,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	For Arterial Insufficiency (Unilateral Or Bilateral System)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0676	Intermittent Limb Compression Device (Includes All Accessories), Not Otherwise	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	Specified	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0677	Non-Pneumatic Sequential Compression Garment, Trunk	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0678	Non-Pneumatic Sequential Compression Garment, Full Leg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
E0679	Non-Pneumatic Sequential Compression Garment, Half Leg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
E0680	Non-Pneumatic Compression Controller With Sequential Calibrated Gradient	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Pressure	Medical Policy Criteria. Submit for Recommended		1-7017-200
	1,155531.5	Clinical Review to avoid post-service review.		
E0681	Non-Pneumatic Compression Controller Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	The state of the s	Medical Policy Criteria. Submit for Recommended		12/01/2000
		Clinical Review to avoid post-service review.		
E0682	Non-Pneumatic Sequential Compression Garment, Full Arm	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Tron't noumand doquernian domproposion dumoni, i am i min	Medical Policy Criteria. Submit for Recommended		12/01/2000
		Clinical Review to avoid post-service review.		
E0691	Ultraviolet Light Therapy System, Includes Bulbs/Lamps, Timer And Eye	MP Criteria: Procedure/service reviewed against	1/15/2008	12/31/2999
_0001	Protection; Treatment Area 2 Square Feet Or Less	Medical Policy Criteria. Submit for Recommended	17 10/2000	12/01/2000
	1. 15.55 fiori, Troubinotic field 2 oqual o 1 oot of 2000	Clinical Review to avoid post-service review.		
=0692	Ultraviolet Light Therapy System Panel, Includes Bulbs/Lamps, Timer And Eye	MP Criteria: Procedure/service reviewed against	1/15/2008	12/31/2999
_0002	Protection, 4 Foot Panel	Medical Policy Criteria. Submit for Recommended	1/10/2000	12/01/2000
	I TOGOLION, 4 TOOL FAIICI	Clinical Review to avoid post-service review.		
E0693	Ultraviolet Light Therapy System Panel, Includes Bulbs/Lamps, Timer And Eye	MP Criteria: Procedure/service reviewed against	1/15/2008	12/31/2999
=0093			1/13/2006	12/31/2999
	Protection, 6 Foot Panel	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E0694	Ultraviolet Multidirectional Light Therapy System In 6 Foot Cabinet, Includes Bulbs/Lamps, Timer And Eye Protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/15/2008	12/31/2999
E0705	Transfer Device, Any Type, Each	Clinical Review to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
E0720	Transcutaneous Electrical Nerve Stimulation (Tens) Device, Two Lead, Localized Stimulation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/25/2013	12/31/2999
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device, Four Or More Leads, For Multiple Nerve Stimulation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/25/2013	12/31/2999
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2021	12/31/2999
E0732	Cranial Electrotherapy Stimulation (Ces) System, Any Type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0733	Transcutaneous Electrical Nerve Stimulator For Electrical Stimulation Of The Trigeminal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0734	External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0735	Non-Invasive Vagus Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
E0736	Transcutaneous Tibial Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0739	Rehabilitation System With Interactive Interface Providing Active Assistance In Rehabilitation Therapy, Includes All Components And Accessories, Motors, Microprocessors, Sensors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E0740	Non-Implanted Pelvic Floor Electrical Stimulator, Complete System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
E0744	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0746	Electromyography (Emg), Biofeedback Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0747	Osteogenesis Stimulator, Electrical, Non-Invasive, Other Than Spinal Applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0760	Osteogenesis Stimulator, Low Intensity Ultrasound, Non-Invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

E0761	Non-Thermal Pulsed High Frequency Radiowaves, High Peak Power Electromagnetic Energy Treatment Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
E0762	Transcutaneous Electrical Joint Stimulation Device System, Includes All Accessories	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan.  Not subject to pre-service review. Check EIU  policy, which is one of our Clinical Payment and  Coding Policy (CPCP).	12/15/2014	12/31/2999
E0764	Functional Neuromuscular Stimulation, Transcutaneous Stimulation Of Sequential Muscle Groups Of Ambulation With Computer Control, Used For Walking By Spinal Cord Injured, Entire System, After Completion Of Training Program	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
E0766	Electrical Stimulation Device Used For Cancer Treatment, Includes All Accessories, Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E0769	Electrical Stimulation Or Electromagnetic Wound Treatment Device, Not Otherwise Classified	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
E0782	Infusion Pump, Implantable, Non-Programmable (Includes All Components, E. G. Pump, Catheter, Connectors, Etc. )	, MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0783	Infusion Pump System, Implantable, Programmable (Includes All Components, E. G. , Pump, Catheter, Connectors, Etc. )	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0784	External Ambulatory Infusion Pump, Insulin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0785	Implantable Intraspinal (Epidural/Intrathecal) Catheter Used With Implantable Infusion Pump, Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0786	Implantable Programmable Infusion Pump, Replacement (Excludes Implantable Intraspinal Catheter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0787	External Ambulatory Infusion Pump, Insulin, Dosage Rate Adjustment Using Therapeutic Continuous Glucose Sensing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
E0830	Ambulatory Traction Device, All Types, Each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
E0840	Traction Frame, Attached To Headboard, Cervical Traction	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
E0849	Traction Equipment, Cervical, Free-Standing Stand/Frame, Pneumatic, Applying Traction Force To Other Than Mandible	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999

E0850	Traction Stand, Free Standing, Cervical Traction	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0855	Cervical Traction Equipment Not Requiring Additional Stand Or Frame	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0856	Cervical Traction Device, With Inflatable Air Bladder(S)	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0860	Traction Equipment, Overdoor, Cervical	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0890	Traction Frame, Attached To Footboard, Pelvic Traction	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0920	Fracture Frame, Attached To Bed, Includes Weights	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0930	Fracture Frame, Free Standing, Includes Weights	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0935	Continuous Passive Motion Exercise Device For Use On Knee Only	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0936	Continuous Passive Motion Exercise Device For Use Other Than Knee	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0941	Gravity Assisted Traction Device, Any Type	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E0946	Fracture, Frame, Dual With Cross Bars, Attached To Bed, (E. G. Balken, 4 Poster)	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0947	Fracture Frame, Attachments For Complex Pelvic Traction	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	1	Clinical Review to avoid post-service review.		

E0948	Fracture Frame, Attachments For Complex Cervical Traction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
		Clinical Review to avoid post-service review.		
E0950	Wheelchair Accessory, Tray, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
20000	Tribolonali ricocccity, rray, Edon	Medical Policy Criteria. Submit for Recommended	0/10/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0953	Wheelchair Accessory, Lateral Thigh Or Knee Support, Any Type Including Fixed	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Mounting Hardware, Each	Medical Policy Criteria. Submit for Recommended	1, 1,2010	12/01/2000
		Clinical Review to avoid post-service review.		
E0954	Wheelchair Accessory, Foot Box, Any Type, Includes Attachment And Mounting	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Hardware, Each Foot	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0955	Wheelchair Accessory, Headrest, Cushioned, Any Type, Including Fixed Mounting	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Hardware, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0969	Narrowing Device, Wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0981	Wheelchair Accessory, Seat Upholstery, Replacement Only, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0982	Wheelchair Accessory, Back Upholstery, Replacement Only, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0983	Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Motorized Wheelchair, Joystick Control	Medical Policy Criteria. Submit for Recommended		
	, and the second	Clinical Review to avoid post-service review.		
E0984	Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Motorized Wheelchair, Tiller Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0985	Wheelchair Accessory, Seat Lift Mechanism	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0986	Manual Wheelchair Accessory, Push-Rim Activated Power Assist System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0988	Manual Wheelchair Accessory, Lever-Activated, Wheel Drive, Pair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0990	Wheelchair Accessory, Elevating Leg Rest, Complete Assembly, Each	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0992	Manual Wheelchair Accessory, Solid Seat Insert	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1002	Wheelchair Accessory, Power Seating System, Tilt Only	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E1003	Wheelchair Accessory, Power Seating System, Recline Only, Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
E1004	Wheelchair Accessory, Power Seating System, Recline Only, With Mechanical Shear Reduction	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
E1005	Wheelchair Accessory, Power Seatng System, Recline Only, With Power Shear	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Reduction	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
1006	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, Without Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
1007	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1008	Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Power Shear Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1009	Wheelchair Accessory, Addition To Power Seating System, Mechanically Linked Leg Elevation System, Including Pushrod And Leg Rest, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1010	Wheelchair Accessory, Addition To Power Seating System, Power Leg Elevation System, Including Leg Rest, Pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1012	Wheelchair Accessory, Addition To Power Seating System, Center Mount Power Elevating Leg Rest/Platform, Complete System, Any Type, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
1028	Wheelchair Accessory, Manual Swingaway, Retractable Or Removable Mounting Hardware For Joystick, Other Control Interface Or Positioning Accessory	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1031	Rollabout Chair, Any And All Types With Castors 5 Or Greater	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
1035	Multi-Positional Patient Transfer System, With Integrated Seat, Operated By Care Giver, Patient Weight Capacity Up To And Including 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
1036	Multi-Positional Patient Transfer System, Extra-Wide, With Integrated Seat, Operated By Caregiver, Patient Weight Capacity Greater Than 300 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
1037	Transport Chair, Pediatric Size	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
1038	Transport Chair, Adult Size, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1039	Transport Chair, Adult Size, Heavy Duty, Patient Weight Capacity Greater Than 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

E1050	Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/15/2014	12/31/2999
		Clinical Review to avoid post-service review.		
E1060	Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Detachable Elevating Legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<b>=1070</b>	Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Detachable Footrest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1083	Hemi-Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Rest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1084	Hemi-Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Detachable Elevating Leg Rests	Medical Policy Criteria. Submit for Recommended	0, 10, 20	12,01,2000
	Bottonasio Elevating Log Nooto	Clinical Review to avoid post-service review.		
E1085	Hemi-Wheelchair, Fixed Full Length Arms, Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1000	Thomas Willocionali, i ixod i dii Eongan Annio, owing Away Detachable i oot Nests	Medical Policy Criteria. Submit for Recommended	0/10/2014	1210112333
		Clinical Review to avoid post-service review.		
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length, Swing Away Detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
= 1000	Footrests	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
	rootiests			
-1007	Ulinh Otron all Linktonial (Microtologic Fired Full Lorenth Assoc Onion Access	Clinical Review to avoid post-service review.	0/45/0044	40/04/0000
E1087	High Strength Lightweight Wheelchair, Fixed Full Length Arms, Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Detachable Elevating Leg Rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1088	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1089	High Strength Lightweight Wheelchair, Fixed Length Arms, Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Detachable Footrest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1090	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Swing Away Detachable Foot Rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1092	Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Away Detachable Elevating Leg Rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1093	Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Away Detachable Footrests	Medical Policy Criteria. Submit for Recommended		
	, <b>,</b>	Clinical Review to avoid post-service review.		
<b>E1100</b>	Semi-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Elevating Leg Rests	Medical Policy Criteria. Submit for Recommended	5, 70,2011	.2,01,2000
	Liotaing Log (100to	Clinical Review to avoid post-service review.		
E1110	Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Leg	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1110	Rest	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/3/1/2333
	1/621	Clinical Review to avoid post-service review.		
=1120	Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable	MD Criteria: Precedure/service reviewed a refined	3/15/2014	12/31/2999
≣1130		MP Criteria: Procedure/service reviewed against	3/15/2014	12/3/1/2999
	Footrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		ĺ

E1140	Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/15/2014	12/31/2999
		Clinical Review to avoid post-service review.		
E1150	Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Elevating Legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<u> </u>	Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	The state of the s	Medical Policy Criteria. Submit for Recommended	0, 10, 20 1 1	.2/01/2000
		Clinical Review to avoid post-service review.		
E1161	Manual Adult Size Wheelchair, Includes Tilt In Space	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	manaan naan o zo mnooronan, moraaso mn m opaso	Medical Policy Criteria. Submit for Recommended	0, 10, 20 1 1	.2/01/2000
		Clinical Review to avoid post-service review.		
E1170	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Legrests	Medical Policy Criteria. Submit for Recommended	0, 10, 20 1 1	.2/01/2000
	209,000	Clinical Review to avoid post-service review.		
<u> </u>	Amputee Wheelchair, Fixed Full Length Arms, Without Footrests Or Legrest	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	solonan, i mod i an Eorigan / arrio, i maiota i ood ooto of Eogroot	Medical Policy Criteria. Submit for Recommended	5, 70,2011	.2,01,2000
		Clinical Review to avoid post-service review.		
E1172	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Without Footrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
-111/2	Or Legrest	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	Of Logicot	Clinical Review to avoid post-service review.		
1180	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1100	Detachable Footrests	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/01/2000
	Detactiable Footiests	Clinical Review to avoid post-service review.		
E1190	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1190	Detachable Elevating Legrests	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
	Detachable Elevating Legiests	Clinical Review to avoid post-service review.		
E1195	Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable	MP Criteria: Procedure/service reviewed against	12/1/2011	12/31/2999
_1195	Elevating Legrests	Medical Policy Criteria. Submit for Recommended	12/1/2011	12/3/1/2999
	Lievaling Legiesis	Clinical Review to avoid post-service review.		
E1200	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
=1200	Amputee Wheelchair, Fixed Full Length Amis, Swing Away Detachable Footlest	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
		1		
E1220	Wheelchair; Specially Sized Or Constructed, (Indicate Brand Name, Model	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
= 1220	Number, If Any) And Justification	Medical Policy Criteria. Submit for Recommended	9/13/2000	12/31/2999
	Number, if Arry) And Justinication	Clinical Review to avoid post-service review.		
E1221	Wheelchair With Fixed Arm, Footrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
= 1221	Wheelchair With Fixed Affil, Footiests	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
E1222	Wheelchair With Fixed Arm, Elevating Legrests	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
=1222	wheelchair with Fixed Arm, Elevating Legrests		3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
74000	Mhaalahair Mith Datashahla Armaa C	Clinical Review to avoid post-service review.	2/45/2044	10/01/0000
E1223	Wheelchair With Detachable Arms, Footrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
74004	Miles del dis Milde Detectoria del America El Control	Clinical Review to avoid post-service review.	0/45/0044	40/04/0000
E1224	Wheelchair With Detachable Arms, Elevating Legrests	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E1225	Wheelchair Accessory, Manual Semi-Reclining Back, (Recline Greater Than 15 Degrees, But Less Than 80 Degrees), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/15/2014	12/31/2999
		Clinical Review to avoid post-service review.		
E1226	Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Degrees), Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1227	Special Height Arms For Wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1228	Special Back Height For Wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1229	Wheelchair, Pediatric Size, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1230	Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	And Model Number	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1231	Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1232	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, With Seating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	System	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1233	Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, Without Seating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	System	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
E1234	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, Without Seating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	System	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1235	Wheelchair, Pediatric Size, Rigid, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1236	Wheelchair, Pediatric Size, Folding, Adjustable, With Seating System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	The section of the se	Medical Policy Criteria. Submit for Recommended	0, 10,2011	12/01/2000
		Clinical Review to avoid post-service review.		
1237	Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Tributation of the state of the	Medical Policy Criteria. Submit for Recommended	0, 10, 20 1 1	12/01/2000
		Clinical Review to avoid post-service review.		
1238	Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
00	5.61dii, i Galdalio Gizo, i Giding, rajuotablo, irritioat Godding Gystolli	Medical Policy Criteria. Submit for Recommended	5, 10,2017	12/01/2000
		Clinical Review to avoid post-service review.		
1239	Power Wheelchair, Pediatric Size, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_ 1200	1 over vincelenal, i culatile olze, ivet otherwise openined	Medical Policy Criteria. Submit for Recommended	0, 10,2014	12/01/2000
		Clinical Review to avoid post-service review.		
1240	Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_ 1270	Detachable, Elevating Legrest	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/3/1/2333
	Detachable, Elevating Legrest			
		Clinical Review to avoid post-service review.		

E1250	Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/15/2014	12/31/2999
		Clinical Review to avoid post-service review.		
E1260	Lightweight Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1200	Detachable Footrest	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
	Detachable Footlest	Clinical Review to avoid post-service review.		
E1270	Lightweight Wheelchair, Fixed Full Length Arms, Swing Away Detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
_1270	Elevating Legrests	Medical Policy Criteria. Submit for Recommended	3/13/2014	12/31/2999
	Lievating Legiests	Clinical Review to avoid post-service review.		
E1280	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
_1200	Legrests	Medical Policy Criteria. Submit for Recommended	9/13/2000	12/31/2999
	Legiesis	Clinical Review to avoid post-service review.		
E1285	Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
L 1203	Theavy Duty Wheelchair, Fixed Full Length Airns, Swing Away Detachable Footlest	Medical Policy Criteria. Submit for Recommended	9/13/2000	12/31/2999
		Clinical Review to avoid post-service review.		
E1290	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
_1230	Detachable Footrest	Medical Policy Criteria. Submit for Recommended	3/13/2000	12/3/1/2999
	Detactionie Footiest	Clinical Review to avoid post-service review.		
E1295	Heavy Duty Wheelchair, Fixed Full Length Arms, Elevating Legrest	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
= 1295	neavy Duty Wheelchair, Fixed Full Length Arms, Elevating Legrest		9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
T4000	Crasial Whatlahair Cast Hairbt Frans Flass	Clinical Review to avoid post-service review.	3/15/2014	40/04/0000
E1296	Special Wheelchair Seat Height From Floor	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
E4007	0 : 100 - 10 - 10 - 10 - 10 - 10 - 10 -	Clinical Review to avoid post-service review.	0/45/0044	10/04/0000
E1297	Special Wheelchair Seat Depth, By Upholstery	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
E4000		Clinical Review to avoid post-service review.	0/45/0044	10/04/0000
E1298	Special Wheelchair Seat Depth And/Or Width, By Construction	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	4/4/4050	10/01/0000
E1300	Whirlpool, Portable (Overtub Type)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
E1301	Whirlpool Tub, Walk-In, Portable	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
E1310	Whirlpool, Non-Portable (Built-In Type)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
E1629	Tablo Hemodialysis System For The Billable Dialysis Service	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1632	Wearable Artificial Kidney, Each	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
E1700	Jaw Motion Rehabilitation System	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1701	Replacement Cushions For Jaw Motion Rehabilitation System, Pkg. Of 6	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E1702	Replacement Measuring Scales For Jaw Motion Rehabilitation System, Pkg. Of 200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2024	12/31/2999
	200	I		
1000	On a second section December 1 and 1	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
1902	Communication Board, Non-Electronic Augmentative Or Alternative	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Communication Device	the Plan. Not subject to pre-service review.		
1905	Virtual Reality Cognitive Behavioral Therapy Device (Cbt), Including Pre-	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Programmed Therapy Software	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Fluid	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2201	Manual Wheelchair Accessory, Nonstandard Seat Frame, Width Greater Than Or	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Equal To 20 Inches And Less Than 24 Inches	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2202	Manual Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
2203	Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 To Less Than	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2200	22 Inches	Medical Policy Criteria. Submit for Recommended	0/10/2000	12/01/2000
	ZZ IIIOIIOS	Clinical Review to avoid post-service review.		
2204	Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 22 To 25 Inches	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2204	IManual Wheelchall Accessory, Nortstandard Seat Frame Depth, 22 To 23 mones	Medical Policy Criteria. Submit for Recommended	9/13/2000	12/31/2999
2222	Marriel Minaclahain Assassant Minacl Look Assauchte Commiste Devices and	Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
2206	Manual Wheelchair Accessory, Wheel Lock Assembly, Complete, Replacement	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2207	Wheelchair Accessory, Crutch And Cane Holder, Each	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2209	Arm Trough, With Or Without Hand Support, Each	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2211	Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2212	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size,	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2213	Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable),	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2210	Any Type, Any Size, Each	Medical Policy Criteria. Submit for Recommended	0/10/2000	12/01/2000
	Any Type, Any Olze, Edon	Clinical Review to avoid post-service review.		
2214	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2214	Invalual Wheelchair Accessory, Pheumanic Caster Tile, Arry Size, Each	<u> </u>	9/13/2000	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
20045	Manual Whatlahain Accessory Tuka For Burnardia Contra Time Accessory	Clinical Review to avoid post-service review.	0/45/0000	40/04/0000
2215	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
2216	Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		

E2217	Manual Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2218	Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2219	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2220	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size,	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Replacement Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2221	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable),	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Any Size, Replacement Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2222	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Wheel, Any Size, Replacement Only, Each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2228	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2230	Manual Wheelchair Accessory, Manual Standing System	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	,, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2231	Manual Wheelchair Accessory, Solid Seat Support Base (Replaces Sling Seat),	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	Includes Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	,	Clinical Review to avoid post-service review.		
2291	Back, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Duoti, Francis, For Foundation Oiles Tribotistical Indianality Finds Francisco	Medical Policy Criteria. Submit for Recommended	0, 10, 2000	12/01/2000
		Clinical Review to avoid post-service review.		
2292	Seat, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Josef, Francis, For Fosiciano Sizo Frincisco and Michael Francisco	Medical Policy Criteria. Submit for Recommended	0, 10, 2000	12/01/2000
		Clinical Review to avoid post-service review.		
2293	Back, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
-2200	Hardware	Medical Policy Criteria. Submit for Recommended	0/10/2000	12/01/2000
	Traidward	Clinical Review to avoid post-service review.		
2294	Seat, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
-2254	Hardware	Medical Policy Criteria. Submit for Recommended	3/13/2000	12/01/2000
	ITAIGWAIG	Clinical Review to avoid post-service review.		
2295	Manual Wheelchair Accessory, For Pediatric Size Wheelchair, Dynamic Seating	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
2295	Frame, Allows Coordinated Movement Of Multiple Positioning Features	Medical Policy Criteria. Submit for Recommended	1/1/2009	12/31/2999
	Frame, Allows Coordinated Movement Of Multiple Positioning Features			
2298	Complex Rehabilitative Power Wheelchair Accessory, Power Seat Elevation	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
2290		_	4/ 1/2024	12/31/2999
	System, Any Type	Medical Policy Criteria. Submit for Recommended		
-0004	NAthered also in Assessment December Observations Constants Asses Toward	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
E2301	Wheelchair Accessory, Power Standing System, Any Type	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2310	Power Wheelchair Accessory, Electronic Connection Between Wheelchair	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Controller And One Power Seating System Motor, Including All Related Electronics, Indicator Feature, Mechanical Function Selection Switch, And Fixed Mounting Hardware	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
<b>Ξ2311</b>	Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors, Including All Related Electronics, Indicator Feature, Mechanical Function Selection Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
E2312	Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
E2313	Power Wheelchair Accessory, Harness For Upgrade To Expandable Controller,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
E2321	Power Wheelchair Accessory, Hand Control Interface, Remote Joystick, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2322	Power Wheelchair Accessory, Hand Control Interface, Multiple Mechanical Switches, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2323	Power Wheelchair Accessory, Specialty Joystick Handle For Hand Control Interface, Prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2324	Power Wheelchair Accessory, Chin Cup For Chin Control Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2325	Power Wheelchair Accessory, Sip And Puff Interface, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Manual Swingaway Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2326	Power Wheelchair Accessory, Breath Tube Kit For Sip And Puff Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2327	Power Wheelchair Accessory, Head Control Interface, Mechanical, Proportional, Including All Related Electronics, Mechanical Direction Change Switch, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2328	Power Wheelchair Accessory, Head Control Or Extremity Control Interface, Electronic, Proportional, Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2329	Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, Mechanical Direction Change Switch, Head Array, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2330	Power Wheelchair Accessory, Head Control Interface, Proximity Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, Mechanical Direction Change Switch, Head Array, And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2331	Power Wheelchair Accessory, Attendant Control, Proportional, Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

E2340	Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
E2341	Power Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
E2342	Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 Or 21 Inches	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
E2343	Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 22-25 Inches	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
E2351	Power Wheelchair Accessory, Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2358	Power Wheelchair Accessory, Group 34 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
E2359	Power Wheelchair Accessory, Group 34 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
E2360	Power Wheelchair Accessory, 22 Nf Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2361	Power Wheelchair Accessory, 22Nf Sealed Lead Acid Battery, Each, (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2362	Power Wheelchair Accessory, Group 24 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2363	Power Wheelchair Accessory, Group 24 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2364	Power Wheelchair Accessory, U-1 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2365	Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2366	Power Wheelchair Accessory, Battery Charger, Single Mode, For Use With Only One Battery Type, Sealed Or Non-Sealed, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2367	Power Wheelchair Accessory, Battery Charger, Dual Mode, For Use With Either Battery Type, Sealed Or Non-Sealed, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2371	Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

E2372	Power Wheelchair Accessory, Group 27 Non-Sealed Lead Acid Battery, Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
		Clinical Review to avoid post-service review.		
2373	Power Wheelchair Accessory, Hand Or Chin Control Interface, Compact Remote	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
2010	Joystick, Proportional, Including Fixed Mounting Hardware	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	boyottok, i roportional, including i nou wounting riaraware	Clinical Review to avoid post-service review.		
2374	Power Wheelchair Accessory, Hand Or Chin Control Interface, Standard Remote	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
2014	Joystick (Not Including Controller), Proportional, Including All Related Electronics	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	And Fixed Mounting Hardware, Replacement Only	Clinical Review to avoid post-service review.		
2375	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
2010	Electronics And Mounting Hardware, Replacement Only	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	Electionics And Modning Hardware, Replacement Only	Clinical Review to avoid post-service review.		
2376	Power Wheelchair Accessory, Expandable Controller, Including All Related	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
2010	Electronics And Mounting Hardware, Replacement Only	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	Licetionics And Mounting Flardware, Replacement Only	Clinical Review to avoid post-service review.		
2377	Power Wheelchair Accessory, Expandable Controller, Including All Related	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
.2011	Electronics And Mounting Hardware, Upgrade Provided At Initial Issue	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	Liectionics And Mounting Hardware, opgrade i Tovided At Initial Issue	Clinical Review to avoid post-service review.		
2397	Power Wheelchair Accessory, Lithium-Based Battery, Each	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
.2391	Power Wheelchair Accessory, Entitionin-Dased Dattery, Lacit	Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
		Clinical Review to avoid post-service review.		
2402	Negative Pressure Wound Therapy Electrical Pump, Stationary Or Portable	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
.2402	Negative Flessure Would Therapy Electrical Fullip, Stationary Of Fortable	Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
2500	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages,	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
2500	Less Than Or Equal To 8 Minutes Recording Time	Medical Policy Criteria. Submit for Recommended	1/1/2004	12/31/2999
	Less Than Of Equal to 6 Minutes Recording Time			
2502	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages,	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
2502	Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time		1/1/2004	12/31/2999
	Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	Medical Policy Criteria. Submit for Recommended		
-0504	Charach Cananatina Davisa Digitizad Charach Haina Da Basandad Massana	Clinical Review to avoid post-service review.	4/4/2004	40/04/0000
2504	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages,	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	Medical Policy Criteria. Submit for Recommended		
-0500	On a de Compartir y Davids - Divitir - d On a de University - De Compartir y	Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
2506	Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages,	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	Greater Than 40 Minutes Recording Time	Medical Policy Criteria. Submit for Recommended		
.0500		Clinical Review to avoid post-service review.	1/1/0001	10/04/0000
2508	Speech Generating Device, Synthesized Speech, Requiring Message Formulation	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	By Spelling And Access By Physical Contact With The Device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1/1/0001	10/01/0000
2510	Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	Message Formulation And Multiple Methods Of Device Access	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1/1/005	10/04/03
2511	Speech Generating Software Program, For Personal Computer Or Personal Digital	_	1/1/2004	12/31/2999
	Assistant	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2512	Accessory For Speech Generating Device, Mounting System	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2599	Accessory For Speech Generating Device, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against	12/1/2007	12/31/2999
	7.0000001y 1 of Openating Borloo, 1101 Other Wild Oldcomed	Medical Policy Criteria. Submit for Recommended	12/1/2007	12/01/2000
		Clinical Review to avoid post-service review.		
<b>=</b> 2602	General Use Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		, . ,
		Clinical Review to avoid post-service review.		
E2603	Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2604	Skin Protection Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2605	Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2606	Positioning Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2607	Skin Protection And Positioning Wheelchair Seat Cushion, Width Less Than 22	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Inches, Any Depth	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2608	Skin Protection And Positioning Wheelchair Seat Cushion, Width 22 Inches Or	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Greater, Any Depth	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2609	Custom Fabricated Wheelchair Seat Cushion, Any Size	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2610	Wheelchair Seat Cushion, Powered	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2611	General Use Wheelchair Back Cushion, Width Less Than 22 Inches, Any Height,	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2612	General Use Wheelchair Back Cushion, Width 22 Inches Or Greater, Any Height,	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2613	Positioning Wheelchair Back Cushion, Posterior, Width Less Than 22 Inches, Any	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Height, Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2614		MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Height, Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2615	Positioning Wheelchair Back Cushion, Posterior-Lateral, Width Less Than 22	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Inches, Any Height, Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2616	Positioning Wheelchair Back Cushion, Posterior-Lateral, Width 22 Inches Or	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Greater, Any Height, Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

E2617	Custom Fabricated Wheelchair Back Cushion, Any Size, Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	9/15/2006	12/31/2999
	inounting Hardware	Clinical Review to avoid post-service review.		
2620	Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2020	Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	Medical Policy Criteria. Submit for Recommended	9/13/2000	12/31/2999
	Less Than 22 moles, Any height, including Any Type wounting hardware	Clinical Review to avoid post-service review.		
2621	Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
2021	22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	•	9/15/2006	12/31/2999
	22 mones of Greater, Any height, including Any Type Mounting hardware	Medical Policy Criteria. Submit for Recommended		
2622	Obia Dartastica Milastalataia Ocat Ocalica Adiastala Milatala Laca Theorem Ocalicata	Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
2022	Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches,	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Any Depth	Medical Policy Criteria. Submit for Recommended		
0000		Clinical Review to avoid post-service review.	4/4/0044	40/04/0000
2623	Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches Or	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Greater, Any Depth	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2624		MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Than 22 Inches, Any Depth	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2625	Skin Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width 22	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Inches Or Greater, Any Depth	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2626	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Wheelchair, Balanced, Adjustable	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2627	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Wheelchair, Balanced, Adjustable Rancho Type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2628	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Wheelchair, Balanced, Reclining	Medical Policy Criteria. Submit for Recommended		
	·	Clinical Review to avoid post-service review.		
2629	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Distal Joints)	Clinical Review to avoid post-service review.		
2630	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support, Monosuspension	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type	Medical Policy Criteria. Submit for Recommended		
	Suspension Support	Clinical Review to avoid post-service review.		
2631	Wheelchair Accessory, Addition To Mobile Arm Support, Elevating Proximal Arm	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2632	Wheelchair Accessory, Addition To Mobile Arm Support, Offset Or Lateral Rocker	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
<b>-</b>	Arm With Elastic Balance Control	Medical Policy Criteria. Submit for Recommended		1.2,0.,2000
	Listo Balairos Golfa ol	Clinical Review to avoid post-service review.		
2633	Wheelchair Accessory, Addition To Mobile Arm Support, Supinator	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	Thiosician Accessiy, Addition to Mobile Ann Capport, Capillator	Medical Policy Criteria. Submit for Recommended	5, 10,2014	12/01/2000
		Clinical Review to avoid post-service review.		
3000	Speech Volume Modulation System, Any Type, Including All Components And	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
0000	Accessories		5/15/2024	12/3/1/2999
	Accessories	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

G0127	Trimming Of Dystrophic Nails, Any Number	MP Criteria: Procedure/service reviewed against	9/15/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
24.00	Intervenie Inferior Of Circular video Alfo Almo Includio Devideo Oromalia	Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
138	Intravenous Infusion Of Cipaglucosidase Alfa-Atga, Including Provider/Supplier	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Acquisition And Clinical Supervision Of Oral Administration Of Miglustat In	Medical Policy Criteria. Submit for Recommended		
	Preparation Of Receipt Of Cipaglucosidase Alfa-Atga	Clinical Review to avoid post-service review.		
)151	Services Performed By A Qualified Physical Therapist In The Home Health Or	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Hospice Setting, Each 15 Minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)152	Services Performed By A Qualified Occupational Therapist In The Home Health Or	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Hospice Setting, Each 15 Minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0153	Services Performed By A Qualified Speech-Language Pathologist In The Home	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Health Or Hospice Setting, Each 15 Minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0157	Services Performed By A Qualified Physical Therapist Assistant In The Home	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Health Or Hospice Setting, Each 15 Minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)158	Services Performed By A Qualified Occupational Therapist Assistant In The Home	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
7100	Health Or Hospice Setting, Each 15 Minutes	Medical Policy Criteria. Submit for Recommended	1, 1, 2011	12/01/2000
	Treatiti of Flospice Octaing, Each To Milliates	Clinical Review to avoid post-service review.		
0159	Services Performed By A Qualified Physical Therapist, In The Home Health	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
7109	Setting, In The Establishment Or Delivery Of A Safe And Effective Physical	Medical Policy Criteria. Submit for Recommended	1/1/2011	12/31/2999
		1		
24.00	Therapy Maintenance Program, Each 15 Minutes  Services Performed By A Qualified Occupational Therapist, In The Home Health	Clinical Review to avoid post-service review.	4/4/0044	12/31/2999
0160		MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Setting, In The Establishment Or Delivery Of A Safe And Effective Occupational	Medical Policy Criteria. Submit for Recommended		
2404	Therapy Maintenance Program, Each 15 Minutes	Clinical Review to avoid post-service review.	0/45/0045	40/04/0000
0161	Services Performed By A Qualified Speech-Language Pathologist, In The Home	MP Criteria: Procedure/service reviewed against	3/15/2015	12/31/2999
	Health Setting, In The Establishment Or Delivery Of A Safe And Effective Speech-	Medical Policy Criteria. Submit for Recommended		
	Language Pathology Maintenance Program, Each 15 Minutes	Clinical Review to avoid post-service review.		
0166	External Counterpulsation, Per Treatment Session	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
)176	Activity Therapy, Such As Music, Dance, Art Or Play Therapies Not For	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	Recreation, Related To The Care And Treatment Of Patient'S Disabling Mental	Medical Policy Criteria. Submit for Recommended		
	Health Problems, Per Session (45 Minutes Or More)	Clinical Review to avoid post-service review.		
0177	Training And Educational Services Related To The Care And Treatment Of	MP Criteria: Procedure/service reviewed against	9/15/2011	12/31/2999
	Patient'S Disabling Mental Health Problems Per Session (45 Minutes Or More)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0255	Current Perception Threshold/Sensory Nerve Conduction Test, (Snct) Per Limb,	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Any Nerve	Not subject to pre-service review. Check EIU	,,	
	,, 16.13	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)276	Blinded Procedure For Lumbar Stenosis, Percutaneous Image-Guided Lumbar	Non Covered: Procedure/service not covered by	1/1/2015	12/31/2999
210	Decompression (Pild) Or Placebo-Control, Performed In An Approved Coverage	the Plan. Not subject to pre-service review.	17 172010	12/01/2000
	With Evidence Development (Ced) Clinical Trial	The Flan. Not subject to pre-service review.		
0281		Elli. Dropoduro/ganvigo net reimburged by the Dier	0/1/2020	12/31/2999
1201		EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	And Stage Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers, And Venous Statsis			
	Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of	policy, which is one of our Clinical Payment and		
	Conventional Care, As Part Of A Therapy Plan Of Care	Coding Policy (CPCP).		

G0282	Electrical Stimulation, (Unattended), To One Or More Areas, For Wound Care	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	Other Than Described In G0281	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
G0283	Electrical Stimulation (Unattended), To One Or More Areas For Indication(S) Other		10/15/2016	12/31/2999
	Than Wound Care, As Part Of A Therapy Plan Of Care	the Plan. Not subject to pre-service review.		
G0293	Noncovered Surgical Procedure(S) Using Conscious Sedation, Regional, General	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Or Spinal Anesthesia In A Medicare Qualifying Clinical Trial, Per Day	the Plan. Not subject to pre-service review.		
G0294	Noncovered Procedure(S) Using Either No Anesthesia Or Local Anesthesia Only,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	In A Medicare Qualifying Clinical Trial, Per Day	the Plan. Not subject to pre-service review.		
G0295	Electromagnetic Therapy, To One Or More Areas, For Wound Care Other Than	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	Described In G0329 Or For Other Uses	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
G0302	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs, Complete	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
00002	Course Of Services, To Include A Minimum Of 16 Days Of Services	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
	Source of Services, To morage A minimum of to Baye of Services	Clinical Review to avoid post-service review.		
G0303	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs, 10 To 15	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
00000	Days Of Services	Medical Policy Criteria. Submit for Recommended	1/1/2004	12/01/2000
	Days of Services	Clinical Review to avoid post-service review.		
G0304	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs, 1 To 9 Days	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
G0304	Of Services	Medical Policy Criteria. Submit for Recommended	1/1/2004	12/31/2999
	Of Services			
00005	Doot Dischause Dulmanamy Common Comitoes After Lyne Ministry of C. Davis Of	Clinical Review to avoid post-service review.	1/1/2004	40/04/0000
G0305	Post-Discharge Pulmonary Surgery Services After Lvrs, Minimum Of 6 Days Of	MP Criteria: Procedure/service reviewed against	1/1/2004	12/31/2999
	Services	Medical Policy Criteria. Submit for Recommended		
00010		Clinical Review to avoid post-service review.	= 1.1.1.100.00	10/01/0000
G0310	Immunization Counseling By A Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional When The Vaccine(S) Is Not Administered On The Same Date Of	the Plan. Not subject to pre-service review.		
	Service, 5 To 15 Mins Time (This Code Is Used For Medicaid Billing Purposes)			
G0311	Immunization Counseling By A Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional When The Vaccine(S) Is Not Administered On The Same Date Of	the Plan. Not subject to pre-service review.		
	Service, 16-30 Mins Time (This Code Is Used For Medicaid Billing Purposes)			
G0312	Immunization Counseling By A Physician Or Other Qualify Ed Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional When The Vaccine(S) Is Not Administered On The Same Date Of	the Plan. Not subject to pre-service review.		
	Service For Ages Under 21, 5 To 15 Mins Time (This Code Is Used For Medicaid			
	Billing Purposes)			
G0313	Immunization Counseling By A Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional When The Vaccine(S) Is Not Administered On The Same Date Of	the Plan. Not subject to pre-service review.		
	Service For Ages Under 21, 16-30 Mins Time (This Code Is Used For Medicaid			
	Billing Purposes)			
G0314	Immunization Counseling By A Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional For Covid-19, Ages Under 21, 16-30 Mins Time (This Code Is Used	the Plan. Not subject to pre-service review.		
	For The Medicaid Early And Periodic Screening, Diagnostic, And Treatment	, i		
	Benefit (Epsdt)			
G0315	Immunization Counseling By A Physician Or Other Qualified Health Care	Non Covered: Procedure/service not covered by	5/11/2022	12/31/2999
	Professional For Covid-19, Ages Under 21, 5-15 Mins Time (This Code Is Used	the Plan. Not subject to pre-service review.		,,
	For The Medicaid Early And Periodic Screening, Diagnostic, And Treatment	The Figure 110t out jobt to pro dor 100 Toviow.		
	Benefit (Epsdt)			

G0316	Dueloused Heavital Investigat On Observation Core Fuglishing And Management	Non Covered Dropedum/comice not covered by	4/4/0000	40/04/0000
G0316	Prolonged Hospital Inpatient Or Observation Care Evaluation And Management	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Service(S) Beyond The Total Time For The Primary Service (When The Primary	the Plan. Not subject to pre-service review.		
	Service Has Been Selected Using Time On The Date Of The Primary Service);			
	Each Additional 15 Minutes By The Physician Or Qualified Healthcare			
	Professional, With Or Without Direct Patient Contact (List Separately In Addition			
	To Cpt Codes 99223, 99233, And 99236 For Hospital Inpatient Or Observation			
	Care Evaluation And Management Services). (Do Not Report G0316 On The			
	Same Date Of Service As Other Prolonged Services For Evaluation And			
	Management 99358, 99359, 99418, 99415, 99416). (Do Not Report G0316 For			
	Anv Time Unit Less Than 15 Minutes)			
G0317	Prolonged Nursing Facility Evaluation And Management Service(S) Beyond The	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Total Time For The Primary Service (When The Primary Service Has Been	the Plan. Not subject to pre-service review.		
	Selected Using Time On The Date Of The Primary Service); Each Additional 15			
	Minutes By The Physician Or Qualified Healthcare Professional, With Or Without			
	Direct Patient Contact (List Separately In Addition To Cpt Codes 99306, 99310 For			
	Nursing Facility Evaluation And Management Services). (Do Not Report G0317 On			
	The Same Date Of Service As Other Prolonged Services For Evaluation And			
	Management 99358, 99359, 99418). (Do Not Report G0317 For Any Time Unit			
	Less Than 15 Minutes)			
G0318	Prolonged Home Or Residence Evaluation And Management Service(S) Beyond	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	The Total Time For The Primary Service (When The Primary Service Has Been	the Plan. Not subject to pre-service review.		
	Selected Using Time On The Date Of The Primary Service); Each Additional 15			
	Minutes By The Physician Or Qualified Healthcare Professional, With Or Without			
	Direct Patient Contact (List Separately In Addition To Cpt Codes 99345, 99350 For			
	Home Or Residence Evaluation And Management Services). (Do Not Report			
	G0318 On The Same Date Of Service As Other Prolonged Services For			
	Evaluation And Management 99358, 99359, 99417). (Do Not Report G0318 For			
	Anv Time Unit Less Than 15 Minutes)			
G0329	Electromagnetic Therapy, To One Or More Areas For Chronic Stage Iii And Stage	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
00020	Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers And Venous Stasis Ulcers Not	Not subject to pre-service review. Check EIU	0/1/2020	12/01/2000
	Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care	policy, which is one of our Clinical Payment and		
	As Part Of A Therapy Plan Of Care	Coding Policy (CPCP).		
G0330	Facility Services For Dental Rehabilitation Procedure(S) Performed On A Patient	MP Criteria: Procedure/service reviewed against	10/15/2023	12/31/2999
00000	Who Requires Monitored Anesthesia (E.G., General, Intravenous Sedation	Medical Policy Criteria. Submit for Recommended	10/10/2020	12/01/2000
	(Monitored Anesthesia Care) And Use Of An Operating Room	Clinical Review to avoid post-service review.		
G0333	Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
00000	Beneficiary	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/31/2333
	Deficically	Clinical Review to avoid post-service review.		
G0341	Percutaneous Islet Cell Transplant, Includes Portal Vein Catheterization And	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
00041	Infusion	Medical Policy Criteria. Submit for Recommended	112112003	12/3/1/2333
	IIIIuSiUII	Clinical Review to avoid post-service review.		
G0342	Laparoscopy For Islet Cell Transplant, Includes Portal Vein Catheterization And	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
G0342	· · · · · · · · · · · · · · · · · · ·		112112009	12/31/2999
	Infusion	Medical Policy Criteria. Submit for Recommended		
C0242	Langratomy For Joint Coll Transplant, Included Deutel Vein Ceth steel-steel Aud	Clinical Review to avoid post-service review.	7/27/2000	10/21/2000
G0343	Laparotomy For Islet Cell Transplant, Includes Portal Vein Catheterization And	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Infusion	Medical Policy Criteria. Submit for Recommended		
00070	Distriction Country Descriptor IT. Fetable I.A. ID. (T. N. 15. A.)	Clinical Review to avoid post-service review.	40/05/0005	40/04/0000
G0372	Physician Service Required To Establish And Document The Need For A Power	Non Covered: Procedure/service not covered by	10/25/2005	12/31/2999
	Mobility Device (Use In Addition To Primary Evaluation And Management Code)	the Plan. Not subject to pre-service review.		

G0422	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With	MP Criteria: Procedure/service reviewed against	12/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0423	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring;	MP Criteria: Procedure/service reviewed against	12/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0428		EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
G0429		MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	(Lds) (E.G., As A Result Of Highly Active Antiretroviral Therapy.)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0448		MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Pacing Electrode, Cardiac Venous System, For Left Ventricular Pacing	Clinical Review to avoid post-service review.		
G0455	Preparation With Instillation Of Fecal Microbiota By Any Method, Including	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Assessment Of Donor Specimen	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0460	Autologous Platelet Rich Plasma Or Other Blood-Derived Product For Non-	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Diabetic Chronic Wounds/Ulcers, Including As Applicable Phlebotomy,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
	And Dressings, Per Treatment	Coding Policy (CPCP).		
G0465		EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
00540	Centrifugation Or Mixing, And All Other Preparatory Procedures, Per Treatment)	Coding Policy (CPCP).	4/4/0040	10/01/0000
G0516		MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
00547		Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
G0517		MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	Subdermal Implants)	Medical Policy Criteria. Submit for Recommended		
00540	Removal With Reinsertion, Non-Biodegradable Drug Delivery Implants, 4 Or More	Clinical Review to avoid post-service review.	1/1/2018	40/04/0000
G0518		Medical Policy Criteria. Submit for Recommended	1/1/2018	12/31/2999
	(Services For Subdermar implants)	•		
G2011	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment	Clinical Review to avoid post-service review.  Non Covered: Procedure/service not covered by	1/1/2019	12/31/2999
G2011	·	•	1/1/2019	12/3 1/2999
G2082	(E.G., Audit, Dast), And Brief Intervention, 5-14 Minutes  Office Or Other Outpatient Visit For The Evaluation And Management Of An	the Plan. Not subject to pre-service review.  MP Criteria: Procedure/service reviewed against	8/1/2021	12/31/2999
G2002		Medical Policy Criteria. Submit for Recommended	0/1/2021	12/31/2888
		Clinical Review to avoid post-service review.		
	Nasal Self-Administration, Includes 2 Hours Post-Administration Observation	Cirrical Review to avoid post-service review.		
G2083		MP Criteria: Procedure/service reviewed against	8/1/2021	12/31/2999
G2003		Medical Policy Criteria. Submit for Recommended	0/1/2021	12/31/2888
	Qualified Health Care Professional And Provision Of Greater Than 56 Mg	Clinical Review to avoid post-service review.		
I	Esketamine Nasal Self-Administration, Includes 2 Hours Post-Administration	Cirrical Neview to avoid post-service review.		
	· · · · · · · · · · · · · · · · · · ·			
	Observation			

G3002	Chronic Pain Management And Treatment, Monthly Bundle Including, Diagnosis; Assessment And Monitoring; Administration Of A Validated Pain Rating Scale Or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
	Tool; The Development, Implementation, Revision, And/Or Maintenance Of A			
	Person-Centered Care Plan That Includes Strengths, Goals, Clinical Needs, And			
	Desired Outcomes; Overall Treatment Management; Facilitation And Coordination			
	Of Any Necessary Behavioral Health Treatment; Medication Management; Pain			
	And Health Literacy Counseling; Any Necessary Chronic Pain Related Crisis Care;			
	And Ongoing Communication And Care Coordination Between Relevant			
	Practitioners Furnishing Care, E.G. Physical Therapy And Occupational Therapy,			
	Complementary And Integrative Approaches, And Community-Based Care, As Appropriate. Required Initial Face-To-Face Visit At Least 30 Minutes Provided By			
	A Physician Or Other Qualified Health Professional; First 30 Minutes Personally			
	Provided By Physician Or Other Qualified Health Care Professional, Per Calendar			
	Month. (When Using G3002, 30 Minutes Must Be Met Or Exceeded.)			
G3003	Each Additional 15 Minutes Of Chronic Pain Management And Treatment By A	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
50000	Physician Or Other Qualified Health Care Professional, Per Calendar Month. (List	the Plan. Not subject to pre-service review.	1/1/2023	12/3/1/2333
	Separately In Addition To Code For G3002. When Using G3003, 15 Minutes Must	The Frank. Not subject to pre-service review.		
	Be Met Or Exceeded.)			
G8395	Left Ventricular Ejection Fraction (Lvef) >= 40% Or Documentation As Normal Or	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8396	Left Ventricular Ejection Fraction (Lvef) Not Performed Or Documented	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8397	Dilated Macular Or Fundus Exam Performed, Including Documentation Of The	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8399	0, , ,	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
G8400	(Dxa) Ever Being Performed Patient With Central Dual-Energy X-Ray Absorptiometry (Dxa) Results Not	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
G0400	Documented, Reason Not Given	the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G8404	Lower Extremity Neurological Exam Performed And Documented	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
00101	Lower Extremity Neurological Examin offender And Bootimonica	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
G8405	Lower Extremity Neurological Exam Not Performed	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8410	Footwear Evaluation Performed And Documented	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8415	Footwear Evaluation Was Not Performed	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8416	Clinician Documented That Patient Was Not An Eligible Candidate For Footwear	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
		the Plan. Not subject to pre-service review.		
G8417	Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
00440	Documented	the Plan. Not subject to pre-service review.	4/4/0000	40/04/0000
G8418	Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
G8419	Documented  Bmi Documented Outside Normal Parameters, No Follow-Up Plan Documented,	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
G04 19	No Reason Given	1	1/1/2006	12/3/1/2999
G8420	Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
00420	Required	the Plan. Not subject to pre-service review.	1/1/2006	12/3/1/2999
G8421	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
00721	Dill Not Docamented And No Neason is Olven	the Plan. Not subject to pre-service review.	1/1/2000	12/3/1/2333

G8427	Eligible Clinician Attests To Documenting In The Medical Record They Obtained, Updated, Or Reviewed The Patient'S Current Medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8428		Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8430	Documentation Of A Medical Reason(S) For Not Documenting, Updating, Or Reviewing The Patient'S Current Medications List (E.G., Patient Is In An Urgent Or Emergent Medical Situation)	Non Covered: Procedure/service not covered by	1/1/2008	12/31/2999
G8431	Screening For Depression Is Documented As Being Positive And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8432	Depression Screening Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8433	Screening For Depression Not Completed, Documented Patient Or Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8450	Beta-Blocker Therapy Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8451	Beta-Blocker Therapy For Lvef <=40% Not Prescribed For Reasons Documented By The Clinician (E.G., Low Blood Pressure, Fluid Overload, Asthma, Patients Recently Treated With An Intravenous Positive Inotropic Agent, Allergy, Intolerance, Other Medical Reasons, Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8452	Beta-Blocker Therapy Not Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8465	High Or Very High Risk Of Recurrence Of Prostate Cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8473	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8474	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed For Reasons Documented By The Clinician (E.G., Allergy, Intolerance, Pregnancy, Renal Failure Due To Ace Inhibitor, Diseases Of The Aortic Or Mitral Valve, Other Medical Reasons) Or (E.G., Patient Declined, Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8475	Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8476	Most Recent Blood Pressure Has A Systolic Measurement Of < 140 Mmhg And A Diastolic Measurement Of < 90 Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8477	Most Recent Blood Pressure Has A Systolic Measurement Of >=140 Mmhg And/Or A Diastolic Measurement Of >=90 Mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8478	Blood Pressure Measurement Not Performed Or Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8482	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8483	Influenza Immunization Was Not Administered For Reasons Documented By Clinician (E.G., Patient Allergy Or Other Medical Reasons, Patient Declined Or Other Patient Reasons, Vaccine Not Available Or Other System Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8484	Influenza Immunization Was Not Administered, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G9050	Oncology; Primary Focus Of Visit; Work-Up, Evaluation, Or Staging At The Time Of Cancer Diagnosis Or Recurrence (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

C00E1	Oncology; Primary Focus Of Visit; Treatment Decision-Making After Disease Is	Man Cayarad, Dragadura/agrica not sayarad by	1/1/2006	12/21/2000
G9051		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Active Cancer Directed Therapy Or Managing Consequences Of Cancer Directed			
	Therapy (For Use In A Medicare-Approved Demonstration Project)			
G9052	Oncology; Primary Focus Of Visit; Surveillance For Disease Recurrence For	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
00002	Patient Who Has Completed Definitive Cancer-Directed Therapy And Currently	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
	Lacks Evidence Of Recurrent Disease; Cancer Directed Therapy Might Be	The Fight 14ot subject to pre service review.		
	Considered In The Future (For Use In A Medicare-Approved Demonstration			
	Project)			
G9053	Oncology; Primary Focus Of Visit; Expectant Management Of Patient With	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Evidence Of Cancer For Whom No Cancer Directed Therapy Is Being	the Plan. Not subject to pre-service review.	., .,	12/01/2000
	Administered Or Arranged At Present; Cancer Directed Therapy Might Be	The Figure 11 of Subject to pro Service 10 flow.		
	Considered In The Future (For Use In A Medicare-Approved Demonstration			
	Project)			
G9054	Oncology; Primary Focus Of Visit; Supervising, Coordinating Or Managing Care Of	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Patient With Terminal Cancer Or For Whom Other Medical Illness Prevents	the Plan. Not subject to pre-service review.		12.011200
	Further Cancer Treatment; Includes Symptom Management, End-Of-Life Care			
	Planning, Management Of Palliative Therapies (For Use In A Medicare-Approved			
	Demonstration Project)			
G9055	Oncology; Primary Focus Of Visit; Other, Unspecified Service Not Otherwise	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Listed (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.		
G9056	Oncology; Practice Guidelines; Management Adheres To Guidelines (For Use In A		1/1/2006	12/31/2999
	Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.		
G9057		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Of Patient Enrollment In An Institutional Review Board Approved Clinical Trial (For			
	Use In A Medicare-Approved Demonstration Project)	, '		
G9058	Oncology; Practice Guidelines; Management Differs From Guidelines Because	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	The Treating Physician Disagrees With Guideline Recommendations (For Use In	the Plan. Not subject to pre-service review.		
	A Medicare-Approved Demonstration Project)			
G9059	Oncology; Practice Guidelines; Management Differs From Guidelines Because	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	The Patient, After Being Offered Treatment Consistent With Guidelines, Has	the Plan. Not subject to pre-service review.		
	Opted For Alternative Treatment Or Management, Including No Treatment (For			
	Use In A Medicare-Approved Demonstration Project)			
G9060	Oncology; Practice Guidelines; Management Differs From Guidelines For	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Reason(S) Associated With Patient Comorbid Illness Or Performance Status Not	the Plan. Not subject to pre-service review.		
	Factored Into Guidelines (For Use In A Medicare-Approved Demonstration Project)			
G9061	Oncology; Practice Guidelines; Patient'S Condition Not Addressed By Available	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
00001	Guidelines (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
G9062	Oncology; Practice Guidelines; Management Differs From Guidelines For Other	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
30002	Reason(S) Not Listed (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.	., .,	12/01/2000
G9063	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Disease Initially Established As Stage I (Prior To Neo-Adjuvant Therapy, If Any)	the Plan. Not subject to pre-service review.		12.011200
	With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use	The real recomposition pro control remains		
	In A Medicare-Approved Demonstration Project)			
G9064	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use	and the samplest to pro-solution.		
	In A Medicare-Approved Demonstration Project)			

G9065	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Disease Initially Established As Stage Iii A (Prior To Neo-Adjuvant Therapy, If Any)			
	With No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use	, '		
	In A Medicare-Approved Demonstration Project)			
G9066	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Stage lii B- lv	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A	the Plan. Not subject to pre-service review.		
	Medicare-Approved Demonstration Project)	, i		
G9067	Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-	the Plan. Not subject to pre-service review.		
	Approved Demonstration Project)			
G9068	Oncology; Disease Status; Limited To Small Cell And Combined Small Cell/Non-	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Small Cell; Extent Of Disease Initially Established As Limited With No Evidence Of	the Plan. Not subject to pre-service review.		
	Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-			
	Approved Demonstration Project)			
G9069	Oncology; Disease Status; Small Cell Lung Cancer, Limited To Small Cell And	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Combined Small Cell/Non-Small Cell; Extensive Stage At Diagnosis, Metastatic,	the Plan. Not subject to pre-service review.		
	Locally Recurrent, Or Progressive (For Use In A Medicare-Approved			
	Demonstration Project)			
G9070	Oncology; Disease Status; Small Cell Lung Cancer, Limited To Small Cell And	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Combined Small Cell/Non-Small; Extent Of Disease Unknown, Staging In	the Plan. Not subject to pre-service review.		
	Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)			
G9071	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Stage lia-lib; Or T3, N1, M0; And Er And/Or Pr Positive; With No Evidence Of			
	Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-			
	Approved Demonstration Project)			
G9072	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I,	the Plan. Not subject to pre-service review.		
	Or Stage lia-lib; Or T3, N1, M0; And Er And Pr Negative; With No Evidence Of			
	Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-			
	Approved Demonstration Project)			
G9073	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-	the Plan. Not subject to pre-service review.		
	liib; And Not T3, N1, M0; And Er And/Or Pr Positive; With No Evidence Of Disease			
	Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved			
	Demonstration Project)			
G9074	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-	the Plan. Not subject to pre-service review.		
	liib; And Not T3, N1, M0; And Er And Pr Negative; With No Evidence Of Disease			
	Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved			
	Demonstration Project)			
G9075	Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; M1 At	the Plan. Not subject to pre-service review.		
	Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-			
	Approved Demonstration Project)			
G9077	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; T1-T2C And Gleason 2-7 And Psa < Or Equal To 20 At	the Plan. Not subject to pre-service review.		
	Diagnosis With No Evidence Of Disease Progression, Recurrence, Or Metastases			
	(For Use In A Medicare-Approved Demonstration Project)			

G9078	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9070		the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
	No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A	, '		
	Medicare-Approved Demonstration Project)			
G9079	Oncology; Disease Status; Prostate Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; T3B-T4, Any N; Any T, N1 At Diagnosis With No Evidence	the Plan. Not subject to pre-service review.		
	Of Disease Progression, Recurrence, Or Metastases (For Use In A Medicare-			
	Approved Demonstration Project)			
G9080		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Initial Treatment With Rising Psa Or Failure Of Psa Decline (For Use In A	the Plan. Not subject to pre-service review.		
	Medicare-Approved Demonstration Project)			
G9083		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-	the Plan. Not subject to pre-service review.		
	Approved Demonstration Project)			
G9084	, , , , , , , , , , , , , , , , , , , ,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Established As T1-3, N0, M0 With No Evidence Of Disease Progression,			
	Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration			
	Project)			
G9085		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Established As T4, N0, M0 With No Evidence Of Disease Progression,			
	Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration			
	Project)			
G9086		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Established As T1-4, N1-2, M0 With No Evidence Of Disease Progression,			
	Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration			
00007	Project)	<u> </u>	4/4/0000	10/04/0000
G9087		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Recurrent, Or Progressive With Current Clinical, Radiologic, Or Biochemical			
	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)			
G9088	Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9000		the Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
		The Flan. Not subject to pre-service review.		
	Recurrent, Or Progressive Without Current Clinical, Radiologic, Or Biochemical			
	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)			
G9089	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9089	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9089	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging		1/1/2006	12/31/2999
G9089	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration		1/1/2006	12/31/2999
	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.		
	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9089 G9090	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially	the Plan. Not subject to pre-service review.		
	Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Colon Cancer, Limited To Invasive Cancer, Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration Project)  Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by		

G9091	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially	the Plan. Not subject to pre-service review.		
	Established As T3, N0, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No			
	Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A			
	Medicare-Approved Demonstration Project)			
G9092	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially	the Plan. Not subject to pre-service review.		
	Established As T1-3, N1-2, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No			
	Evidence Of Disease Progression, Recurrence Or Metastases (For Use In A			
G9093	Medicare-Approved Demonstration Project) Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
G9093		•	1/1/2006	12/31/2999
	Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4, Any N, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No	the Plan. Not subject to pre-service review.		
	Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A			
	Medicare-Approved Demonstration Project)			
G9094	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
00004	Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis, Metastatic, Locally	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
	Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration	The Flam. Not subject to pro service review.		
	Project)			
G9095	Oncology; Disease Status; Rectal Cancer, Limited To Invasive Cancer,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown, Staging	the Plan. Not subject to pre-service review.		
	In Progress, Or Not Listed (For Use In A Medicare-Approved Demonstration	, i		
	Project)			
G9096	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially	the Plan. Not subject to pre-service review.		
	Established As T1-T3, N0-N1 Or Nx (Prior To Neo-Adjuvant Therapy, If Any) With			
	No Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A			
	Medicare-Approved Demonstration Project)			
G9097	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially	the Plan. Not subject to pre-service review.		
	Established As T4, Any N, M0 (Prior To Neo-Adjuvant Therapy, If Any) With No			
	Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A			
C0000	Medicare-Approved Demonstration Project) Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or	Non Covered: Presedure/semiles not severed by	1/1/2006	10/21/2000
G9098	Squamous Cell Carcinoma As Predominant Cell Type; M1 At Diagnosis,	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
	Metastatic, Locally Recurrent, Or Progressive (For Use In A Medicare-Approved	the Plan. Not subject to pre-service review.		
	Demonstration Project)			
G9099	Oncology; Disease Status; Esophageal Cancer, Limited To Adenocarcinoma Or	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
00000	Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
	Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-Approved	,		
	Demonstration Project)			
G9100	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; Post R0 Resection (With Or Without Neoadjuvant	the Plan. Not subject to pre-service review.		
	Therapy) With No Evidence Of Disease Recurrence, Progression, Or Metastases			
	(For Use In A Medicare-Approved Demonstration Project)			
G9101	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; Post R1 Or R2 Resection (With Or Without Neoadjuvant	the Plan. Not subject to pre-service review.		
	Therapy) With No Evidence Of Disease Progression, Or Metastases (For Use In A			
	Medicare-Approved Demonstration Project)			

G9102	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
09102	Predominant Cell Type; Clinical Or Pathologic M0, Unresectable With No Evidence		1/1/2000	12/31/2999
	Of Disease Progression, Or Metastases (For Use In A Medicare-Approved	Title Flant. Not subject to pre-service review.		
	Demonstration Project)			
G9103	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; Clinical Or Pathologic M1 At Diagnosis, Metastatic, Locally	the Plan. Not subject to pre-service review.		
	Recurrent, Or Progressive (For Use In A Medicare-Approved Demonstration	, '		
	Project)			
G9104	Oncology; Disease Status; Gastric Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; Extent Of Disease Unknown, Staging In Progress, Or Not	the Plan. Not subject to pre-service review.		
	Listed (For Use In A Medicare-Approved Demonstration Project)			
G9105	Oncology; Disease Status; Pancreatic Cancer, Limited To Adenocarcinoma As	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Predominant Cell Type; Post R0 Resection Without Evidence Of Disease	the Plan. Not subject to pre-service review.		
	Progression, Recurrence, Or Metastases (For Use In A Medicare-Approved			
	Demonstration Project)			
G9106		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	R1 Or R2 Resection With No Evidence Of Disease Progression, Or Metastases	the Plan. Not subject to pre-service review.		
	(For Use In A Medicare-Approved Demonstration Project)			
G9107	Oncology; Disease Status; Pancreatic Cancer, Limited To Adenocarcinoma;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Unresectable At Diagnosis, M1 At Diagnosis, Metastatic, Locally Recurrent, Or	the Plan. Not subject to pre-service review.		
	Progressive (For Use In A Medicare-Approved Demonstration Project)			
G9108		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A	the Plan. Not subject to pre-service review.		
	Medicare-Approved Demonstration Project)			
G9109	Oncology; Disease Status; Head And Neck Cancer, Limited To Cancers Of Oral	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Extent Of Disease Initially Established As T1-T2 And N0, M0 (Prior To Neo-			
	Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence,			
	Or Metastases (For Use In A Medicare-Approved Demonstration Project)			
G9110	Oncology; Disease Status; Head And Neck Cancer, Limited To Cancers Of Oral	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Cavity, Pharynx And Larynx With Squamous Cell As Predominant Cell Type;	the Plan. Not subject to pre-service review.		
	Extent Of Disease Initially Established As T3-4 And/Or N1-3, M0 (Prior To Neo-			
	Adjuvant Therapy, If Any) With No Evidence Of Disease Progression, Recurrence,			
	Or Metastases (For Use In A Medicare-Approved Demonstration Project)			
G9111		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	At Diagnosis, Metastatic, Locally Recurrent, Or Progressive (For Use In A			
	Medicare-Approved Demonstration Project)			
G9112		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Cavity, Pharynx And Larynx With Squamous Cell As Predominant Cell Type;	the Plan. Not subject to pre-service review.		
	Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A			
	Medicare-Approved Demonstration Project)			
G9113	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
	Recurrence, Or Metastases (For Use In A Medicare-Approved Demonstration			
	Project)			
G9114	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Pathologic Stage Ia-B (Grade 2-3); Or Stage Ic (All Grades); Or Stage Ii; Without	the Plan. Not subject to pre-service review.		
	Evidence Of Disease Progression, Recurrence, Or Metastases (For Use In A			
	Medicare-Approved Demonstration Project)			

G9115	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Pathologic Stage Iii-Iv; Without Evidence Of Progression, Recurrence, Or	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
	Metastases (For Use In A Medicare-Approved Demonstration Project)			
G9116	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Evidence Of Disease Progression, Or Recurrence, And/Or Platinum Resistance	the Plan. Not subject to pre-service review.		
	(For Use In A Medicare-Approved Demonstration Project)	, '		
G9117	Oncology; Disease Status; Ovarian Cancer, Limited To Epithelial Cancer; Extent	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A Medicare-	the Plan. Not subject to pre-service review.		
	Approved Demonstration Project)	, '		
G9123	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Chronic Phase Not In			
	Hematologic, Cytogenetic, Or Molecular Remission (For Use In A Medicare-			
	Approved Demonstration Project)			
G9124	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
JU 124	Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Accelerated Phase	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
	Not In Hematologic Cytogenetic, Or Molecular Remission (For Use In A Medicare-	line i lan. Not subject to pre-service review.		
	Approved Demonstration Project)			
G9125	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
39123		· · · · · · · · · · · · · · · · · · ·	1/1/2000	12/31/2999
	Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Blast Phase Not In	the Plan. Not subject to pre-service review.		
	Hematologic, Cytogenetic, Or Molecular Remission (For Use In A Medicare-			
00100	Approved Demonstration Project)		4/4/0000	10/01/0000
G9126	Oncology; Disease Status; Chronic Myelogenous Leukemia, Limited To	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; In Hematologic,	the Plan. Not subject to pre-service review.		
	Cytogenetic, Or Molecular Remission (For Use In A Medicare-Approved			
	Demonstration Project)			
G9128	Oncology; Disease Status; Limited To Multiple Myeloma, Systemic Disease;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Smoldering, Stage I (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.		
G9129	Oncology; Disease Status; Limited To Multiple Myeloma, Systemic Disease; Stage	·	1/1/2006	12/31/2999
	li Or Higher (For Use In A Medicare-Approved Demonstration Project)	the Plan. Not subject to pre-service review.		
G9130	Oncology; Disease Status; Limited To Multiple Myeloma, Systemic Disease;	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Extent Of Disease Unknown, Staging In Progress, Or Not Listed (For Use In A	the Plan. Not subject to pre-service review.		
	Medicare-Approved Demonstration Project)			
G9140	Frontier Extended Stay Clinic Demonstration; For A Patient Stay In A Clinic	Non Covered: Procedure/service not covered by	10/1/2007	12/31/2999
	Approved For The Cms Demonstration Project; The Following Measures Should	the Plan. Not subject to pre-service review.		
	Be Present: The Stay Must Be Equal To Or Greater Than 4 Hours; Weather Or			
	Other Conditions Must Prevent Transfer Or The Case Falls Into A Category Of			
	Monitoring And Observation Cases That Are Permitted By The Rules Of The			
	Demonstration; There Is A Maximum Frontier Extended Stay Clinic (Fesc) Visit Of			
	48 Hours, Except In The Case When Weather Or Other Conditions Prevent			
	Transfer; Payment Is Made On Each Period Up To 4 Hours, After The First 4			
	Hours			
G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous, By	EIU: Procedure/service not reimbursed by the Plan	12/1/2020	12/31/2999
	Any Means, Guided By The Results Of Measurements For:Respiratory Quotient;	Not subject to pre-service review. Check EIU		.2.0.,2000
		policy, which is one of our Clinical Payment and		
	And/Or Potassium Concentration	Coding Policy (CPCP).		
G9886	Behavioral Counseling For Diabetes Prevention, In-Person, Group, 60 Minutes	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
33000	Denavioral Counseling For Diabetes Frevention, in-Ferson, Group, to Williates	the Plan. Not subject to pre-service review.	1/1/2024	12/3/1/2333
G9887	Behavioral Counseling For Diabetes Prevention, Distance Learning, 60 Minutes		1/1/2024	12/31/2999
39001	Denavioral Counseling For Diabetes Prevention, Distance Learning, 60 Minutes	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		

G9888	Maintenance 5% WI From Baseline Weight In Months 7-12	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
H0031	Mental Health Assessment, By Non-Physician	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110031	iviental mealth Assessment, by Non-Fritysician	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
H0032	Mental Health Service Plan Development By Non-Physician	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110032	iviental fleatin Service Flan Development by Non-Fritysician	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
H0038	Self-Help/Peer Services, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110030	Sell-Help/reel Selvices, rel 13 ivillules	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
H0039	Assertive Community Treatment, Face-To-Face, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110000	Associate Community Treatment, Face-To-Face, Feb. 19 Minutes	the Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
H0040	Assertive Community Treatment Program, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110010	7 Coording Community Trouble Trougham, 1 of Broth	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
H0041	Foster Care, Child, Non-Therapeutic, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	. 55151 54115, 571114, 77511 7715 4754 4754 4754	the Plan. Not subject to pre-service review.	., ., .,	12/01/2000
H0042	Foster Care, Child, Non-Therapeutic, Per Month	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1-1-1-1-1-1
H0043	Supported Housing, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Capportou From John	the Plan. Not subject to pre-service review.	., ., .,	12/01/2000
H0044	Supported Housing, Per Month	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1-1-1-1-1-1
H0045	Respite Care Services, Not In The Home, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	., ., .,	12/01/2000
H0051	Traditional Healing Service	Non Covered: Procedure/service not covered by	4/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		1-1-1-1-1-1
H1010	Non-Medical Family Planning Education, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	100 modes ( anim) ( anim) = 222021011, ( or 20001011	the Plan. Not subject to pre-service review.	., ., .,	12/01/2000
H1011	Family Assessment By Licensed Behavioral Health Professional For State Defined	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Purposes	the Plan. Not subject to pre-service review.		
H2000	Comprehensive Multidisciplinary Evaluation	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2011	Crisis Intervention Service, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	, and the second	the Plan. Not subject to pre-service review.		
H2012	Behavioral Health Day Treatment, Per Hour	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2013	Psychiatric Health Facility Service, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2014	Skills Training And Development, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2015	Comprehensive Community Support Services, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2016	Comprehensive Community Support Services, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2021	Community-Based Wrap-Around Services, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2022	Community-Based Wrap-Around Services, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2023	Supported Employment, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
H2024	Supported Employment, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	,, , , , ,	the Plan. Not subject to pre-service review.		

H2025	Ongoing Support To Maintain Employment, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
110000	0 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	the Plan. Not subject to pre-service review.	4/4/4050	10/04/0000
H2026	Ongoing Support To Maintain Employment, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12027	Development of the Development of March	the Plan. Not subject to pre-service review.	1/1/1950	40/04/0000
12027	Psychoeducational Service, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
10000	0 10% 1 T 1 10 1 D 1514	the Plan. Not subject to pre-service review.	4/4/4050	10/04/0000
12028	Sexual Offender Treatment Service, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
10000	Occupation for the state of the	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
H2029	Sexual Offender Treatment Service, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
H2030	Mental Health Clubhouse Services, Per 15 Minutes	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12030	Werkar Health Clubriouse Services, Fer 15 Wilhales	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
H2031	Mental Health Clubhouse Services, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12031	INTERIAL HEALTH CHUDHOUSE SELVICES, FEI DIEITI	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
12032	Activity Therapy, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12032	Activity Therapy, Fer 15 Millities		1/1/1950	12/31/2999
H2033	Multisystemic Therapy For Juveniles, Per 15 Minutes	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12033	Inviditisystemic Therapy For Juvernies, Fer 15 Millutes	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
H2034	Alcohol And/Or Drug Abuse Halfway House Services, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12034	Alcohol Alid/Of Drug Abuse Hallway House Services, Fel Dielli	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
H2037	Developmental Delay Prevention Activities, Dependent Child Of Client, Per 15	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12037		the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
10172	Minutes Injection, Aducanumab-Avwa, 2 Mg	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
0172	Injection, Aducanumap-Avwa, 2 Mg	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
		Clinical Review to avoid post-service review.		
J0174	Injection, Lecanemab-Irmb, 1 Mg	MP Criteria: Procedure/service reviewed against	7/6/2023	12/31/2999
00174	Injection, Lecanemab-inib, 1 Mg	Medical Policy Criteria. Submit for Recommended	110/2023	12/31/2999
		Clinical Review to avoid post-service review.		
J0175	Injection, Donanemab-Azbt, 2 Mg	MP Criteria: Procedure/service reviewed against	7/2/2024	12/31/2999
10175	Injection, Donaliemab-Azbt, 2 Mg	Medical Policy Criteria. Submit for Recommended	11212024	12/31/2999
		Clinical Review to avoid post-service review.		
J0177	Injection, Aflibercept Hd, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
10 17 7	Injection, Ambercept rid, 1 Mg	Medical Policy Criteria. Submit for Recommended	4/1/2024	12/31/2999
		Clinical Review to avoid post-service review.		
J0178	Injection, Aflibercept, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
10170	Injection, Ambercept, 1 Mg	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/31/2999
		Clinical Review to avoid post-service review.		
0179	Injection, Brolucizumab-Dbll, 1 Mg	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
0173	Injection, brolucizumab-bbil, i Mg	Medical Policy Criteria. Submit for Recommended	0/13/2023	12/31/2999
		Clinical Review to avoid post-service review.		
0215	Injection, Alefacept, 0. 5 Mg	MP Criteria: Procedure/service reviewed against	2/29/2016	12/31/2999
0213	Injection, Aleidoept, 0. J Mg	Medical Policy Criteria. Submit for Recommended	212312010	12/3/1/2333
		Clinical Review to avoid post-service review.		
0217	Injection, Velmanase Alfa-Tycv, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
UZ 1 1	Injection, veimanase Ana-rycv, rivig	Medical Policy Criteria. Submit for Recommended	1/1/2024	12/3/1/2999
		Clinical Review to avoid post-service review.		
10218	Injection, Olipudase Alfa-Rpcp, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
JUZ 10	Injection, Olipudase Alia-Nop, Tivig	Medical Policy Criteria. Submit for Recommended	11112023	12/3/1/2999
		Clinical Review to avoid post-service review.		

J0219	Injection, Avalglucosidase Alfa-Ngpt, 4 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2022	12/31/2999
		Clinical Review to avoid post-service review.		
J0220	Injection, Alglucosidase Alfa, 10 Mg, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
.0220	Injustion, rugiussaluuss ruiu, 15 mg, rust sullarmas spaanisu	Medical Policy Criteria. Submit for Recommended	17.172011	12/01/2000
		Clinical Review to avoid post-service review.		
0222	Injection, Patisiran, 0.1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
.0222	injoodon, radionall, v. ring	Medical Policy Criteria. Submit for Recommended	17172021	12/01/2000
		Clinical Review to avoid post-service review.		
J0223	Injection, Givosiran, 0.5 Mg	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
0220	Injustion, Ortoman, c.o mg	Medical Policy Criteria. Submit for Recommended	11/10/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J0224	Injection, Lumasiran, 0.5 Mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
,022 <del>-</del>	Injection, Edinasiran, 0.0 Mg	Medical Policy Criteria. Submit for Recommended	17 172021	12/01/2000
		Clinical Review to avoid post-service review.		
J0225	Injection, Vutrisiran, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
10223	Injection, valuation and invig	Medical Policy Criteria. Submit for Recommended	1/1/2023	12/31/2999
		Clinical Review to avoid post-service review.		
10248	Injection, Remdesivir, 1Mg	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
10240	Injection, Nemdesivii, mig	Medical Policy Criteria. Submit for Recommended	3/1/2024	12/31/2999
0270	Injection, Alprostadil, 1. 25 Mcg (Code May Be Used For Medicare When Drug	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	11/1/2014	12/31/2999
0270	Administered Under The Direct Supervision Of A Physician, Not For Use When		11/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10075	Drug Is Self Administered) Alprostadil Urethral Suppository (Code May Be Used For Medicare When Drug	Clinical Review to avoid post-service review.	11/1/2014	12/31/2999
J0275		MP Criteria: Procedure/service reviewed against	11/1/2014	12/31/2999
	Administered Under The Direct Supervision Of A Physician, Not For Use When	Medical Policy Criteria. Submit for Recommended		
10.470	Drug Is Self Administered)	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
10470	Injection, Dimercaprol, Per 100 Mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10.10=		Clinical Review to avoid post-service review.	0///000/	10/04/0000
J0485	Injection, Belatacept, 1 Mg	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
10491	Injection, Anifrolumab-Fnia, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0517	Injection, Benralizumab, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0585	Injection, Onabotulinumtoxina, 1 Unit	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0586	Injection, Abobotulinumtoxina, 5 Units	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
10589	Injection, Daxibotulinumtoxina-Lanm, 1 Unit	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

J0600	Injection, Edetate Calcium Disodium, Up To 1000 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
		Clinical Review to avoid post-service review.		
J0775	Injection, Collagenase, Clostridium Histolyticum, 0.01 Mg	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
10791	Injection, Crizanlizumab-Tmca, 5 Mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	,, <u></u>	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
10895	Injection, Deferoxamine Mesylate, 500 Mg	MP Criteria: Procedure/service reviewed against	10/15/2007	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1071	Injection, Testosterone Cypionate, 1Mg	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1203	Injection, Cipaglucosidase Alfa-Atga, 5 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	, -, -, -, -, -, -, -, -, -, -, -, -, -,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11301	Injection, Edaravone, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	injusticity – Latitations, 1 mg	Medical Policy Criteria. Submit for Recommended	., ., _ 0 . 0	.2/0 ./2000
		Clinical Review to avoid post-service review.		
1302	Injection, Sutimlimab-Jome, 10 Mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended	1.0,	
		Clinical Review to avoid post-service review.		
J1303	Injection, Ravulizumab-Cwvz, 10 Mg	MP Criteria: Procedure/service reviewed against	7/15/2020	12/31/2999
	,, ·, ·g	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1304	Injection, Tofersen, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	,, <b>g</b>	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1305	Injection, Evinacumab-Dgnb, 5Mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	3 / 3	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11306	Injection, Inclisiran, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11323	Injection, Elranatamab-Bcmm, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11325	Injection, Epoprostenol, 0. 5 Mg	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	, , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1411	Injection, Etranacogene Dezaparvovec-Drlb, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
11412	Injection, Valoctocogene Roxaparvovec-Rvox, Per MI, Containing Nominal 2 X	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
· · · · —	10^13 Vector Genomes	Medical Policy Criteria. Submit for Recommended		12,5 2000
		Clinical Review to avoid post-service review.	ľ	

J1413	Injection, Delandistrogene Moxeparvovec-Rokl, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
		Clinical Review to avoid post-service review.		
1426	Injection, Casimersen, 10 Mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
1420	Injection, Casimersen, 10 Mg	Medical Policy Criteria. Submit for Recommended	10/1/2021	12/31/2999
		Clinical Review to avoid post-service review.		
1427	Injection, Viltolarsen, 10 Mg	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
1421	Injection, viitolaisen, 10 wg	Medical Policy Criteria. Submit for Recommended	3/1/2021	12/31/2999
		•		
1428	Injection, Eteplirsen, 10 Mg	Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
1428	Injection, Etepiirsen, 10 Mg	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1.100	11. 6. 0.1.6. 40.14	Clinical Review to avoid post-service review.	44/4/0000	40/04/0000
1429	Injection, Golodirsen, 10 Mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1440	Fecal Microbiota, Live - Jslm, 1 MI	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1551	Injection, Immune Globulin (Cutaquig), 100 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1554	Injection, Immune Globulin (Asceniv), 500 Mg	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1576	Injection, Immune Globulin (Panzyga), Intravenous, Non-Lyophilized (E.G., Liquid),	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	500 Mg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1620	Injection, Gonadorelin Hydrochloride, Per 100 Mcg	MP Criteria: Procedure/service reviewed against	7/1/2015	12/31/2999
.020	injustion, contaction right action may	Medical Policy Criteria. Submit for Recommended	.,.,_00	12,01,2000
		Clinical Review to avoid post-service review.		
1632	Injection, Brexanolone, 1 Mg	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
1002	Injection, Diexanolone, 1 wig	Medical Policy Criteria. Submit for Recommended	10/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
1726	Injection, Hydroxyprogesterone Caproate, (Makena), 10 Mg	Non Covered: Procedure/service not covered by	7/15/2023	12/31/2999
1720	injection, rrydroxyprogesterone caproate, (makeria), ro mg	The state of the s	1113/2023	12/31/2999
1729	Injection, Hydroxyprogesterone Caproate, Not Otherwise Specified, 10 Mg	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	7/15/2023	12/31/2999
1729	Injection, Hydroxyprogesterone Caproate, Not Otherwise Specified, 10 Mg		7/15/2023	12/31/2999
1747	Initiation Operational Object AMI	the Plan. Not subject to pre-service review.	E/4/0000	40/04/0000
1747	Injection, Spesolimab-Sbzo, 1 Mg	MP Criteria: Procedure/service reviewed against	5/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1011		Clinical Review to avoid post-service review.	7///0000	10/01/0000
1811	Insulin (Fiasp) For Administration Through Dme (I.E., Insulin Pump) Per 50 Units	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
1812	Insulin (Fiasp), Per 5 Units	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.	1	
1813	Insulin (Lyumjev) For Administration Through Dme (I.E., Insulin Pump) Per 50	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Units	Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		

J1814	Insulin (Lyumjev), Per 5 Units	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1823	Injection, Inebilizumab-Cdon, 1 Mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1930	Injection, Lanreotide, 1 Mg	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1932	Injection, Lanreotide, (Cipla), 1 Mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11951	Injection, Leuprolide Acetate For Depot Suspension (Fensolvi), 0.25 Mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1954	Injection, Leuprolide Acetate For Depot Suspension (Cipla), 7.5 Mg	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2267	Injection, Mirikizumab-Mrkz, 1 Mg	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2320	Injection, Nandrolone Decanoate, Up To 50 Mg	MP Criteria: Procedure/service reviewed against	2/12/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
12327	Injection, Risankizumab-Rzaa, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against	4/15/2024	12/31/2999
	injection, race mass races, mass rolled, ring	Medical Policy Criteria. Submit for Recommended	.,	.2/0 ./2000
		Clinical Review to avoid post-service review.		
12329	Injection, Ublituximab-Xiiy, 1Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
2020	injustion, oblitaninab villy, ring	Medical Policy Criteria. Submit for Recommended	17 172020	12/01/2000
		Clinical Review to avoid post-service review.		
12353	Injection, Octreotide, Depot Form For Intramuscular Injection, 1 Mg	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
2000	Injustion, Outrodiad, Dopot Form For Intramasocial Injustion, Fing	Medical Policy Criteria. Submit for Recommended	0/1/2024	12/01/2000
		Clinical Review to avoid post-service review.		
2354	Injection, Octreotide, Non-Depot Form For Subcutaneous Or Intravenous Injection,	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
2004	25 Mcg	Medical Policy Criteria. Submit for Recommended	3/1/2024	12/31/2999
	25 IVICG	Clinical Review to avoid post-service review.		
2356	Injection, Tezepelumab-Ekko, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
2330	Injection, rezepelumab-Ekko, r Mg	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
2440	Injection, Papaverine Hcl, Up To 60 Mg	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
2440	Injection, Papavenne Hci, Op 10 60 Mg		2/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0500	Interesting Demonstrated and Alfa band Alfa.	Clinical Review to avoid post-service review.	4/4/0004	40/04/0000
2508	Injection, Pegunigalsidase Alfa-lwxj, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	
2777	Injection, Faricimab-Svoa, 0.1 Mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

J2778	Injection, Ranibizumab, 0.1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2779	Injection, Ranibizumab, Via Intravitreal Implant (Susvimo), 0.1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2782	Injection, Avacincaptad Pegol, 0.1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2787	Riboflavin 5'-Phosphate, Ophthalmic Solution, Up To 3 MI	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2796	Injection, Romiplostim, 10 Micrograms	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3032	Injection, Eptinezumab-Jjmr, 1 Mg	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3055	Injection, Talquetamab-Tgvs, 0.25 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3111	Injection, Romosozumab-Aqqg, 1 Mg	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3241	Injection, Teprotumumab-Trbw, 10 Mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3247	Injection, Secukinumab, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against	8/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3299	Injection, Triamcinolone Acetonide (Xipere), 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3355	Injection, Urofollitropin, 75 lu	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
J3393	Injection, Betibeglogene Autotemcel, Per Treatment	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3394	Injection, Lovotibeglogene Autotemcel, Per Treatment	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3396	Injection, Verteporfin, 0.1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3398	Injection, Voretigene Neparvovec-Rzyl, 1 Billion Vector Genomes	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3399	Injection, Onasemnogene Abeparvovec-Xioi, Per Treatment, Up To 5X10^15	MP Criteria: Procedure/service reviewed against	7/1/2020	12/31/2999
	Vector Genomes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

J3401	Beremagene Geperpavec-Svdt For Topical Administration, Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes, Per 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2024	12/31/2999
J3520	Edetate Disodium, Per 150 Mg	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/1950	12/31/2999
J3570	Laetrile, Amygdalin, Vitamin B17	Clinical Review to avoid post-service review.  Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2015	12/31/2999
J7177	Injection, Human Fibrinogen Concentrate (Fibryga), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J7183	Injection, Von Willebrand Factor Complex (Human), Wilate, 1 I.U. Vwf:Rco	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
J7213	Injection, Coagulation Factor Ix (Recombinant), Ixinity, 1 I.U.	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J7308	Aminolevulinic Acid Hcl For Topical Administration, 20%, Single Unit Dosage Form (354 Mg)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J7309	Methyl Aminolevulinate (Mal) For Topical Administration, 16.8%, 1 Gram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
J7311	Injection, Fluocinolone Acetonide, Intravitreal Implant (Retisert), 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2011	12/31/2999
J7312	Injection, Dexamethasone, Intravitreal Implant, 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2011	12/31/2999
J7313	Injection, Fluocinolone Acetonide, Intravitreal Implant (Iluvien), 0.01 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
J7345	Aminolevulinic Acid Hcl For Topical Administration, 10% Gel, 10 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
J7351	Injection, Bimatoprost, Intracameral Implant, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
J7355	Injection, Travoprost, Intracameral Implant, 1 Microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J7402	Mometasone Furoate Sinus Implant, (Sinuva), 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
J7604	Acetylcysteine, Inhalation Solution, Compounded Product, Administered Through	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7607	Levalbuterol, Inhalation Solution, Compounded Product, Administered Through	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Dme, Concentrated Form, 0.5 Mg	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
J7609	Albuterol, Inhalation Solution, Compounded Product, Administered Through Dme,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
,, 000	Unit Dose, 1 Mg	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
	January Control of the Control of th	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7610	Albuterol, Inhalation Solution, Compounded Product, Administered Through Dme,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Concentrated Form, 1 Mg	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7615	Levalbuterol, Inhalation Solution, Compounded Product, Administered Through	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Dme, Unit Dose, 0.5 Mg	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7622	Beclomethasone, Inhalation Solution, Compounded Product, Administered	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Through Dme, Unit Dose Form, Per Milligram	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7624	Betamethasone, Inhalation Solution, Compounded Product, Administered Through	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Dme, Unit Dose Form, Per Milligram	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7627	Budesonide, Inhalation Solution, Compounded Product, Administered Through	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Dme, Unit Dose Form, Up To 0.5 Mg	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7628	Bitolterol Mesylate, Inhalation Solution, Compounded Product, Administered	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Through Dme, Concentrated Form, Per Milligram	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
J7629	Bitolterol Mesylate, Inhalation Solution, Compounded Product, Administered	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Through Dme, Unit Dose Form, Per Milligram	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
17000	One was here On the second states of One second at Broad and Administration of	Coding Policy (CPCP).	40/4/0000	40/04/0000
J7632	Cromolyn Sodium, Inhalation Solution, Compounded Product, Administered		12/1/2020	12/31/2999
	Through	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
J7634	Budesonide, Inhalation Solution, Compounded Product, Administered Through	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
17034	Dme, Concentrated Form, Per 0.25 Milligram	Not subject to pre-service review. Check EIU	12/1/2020	12/31/2999
	Diffe, Concentrated Form, Per 0.25 Willingram			
		policy, which is one of our Clinical Payment and		
J7635	Atropine, Inhalation Solution, Compounded Product, Administered Through Dme,	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
11000	Concentrated Form, Per Milligram	Not subject to pre-service review. Check EIU	12/1/2020	12/3/1/2999
	Concentrated Form, Per Willigram	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

J7636	Atropine, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7637	Dexamethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7638	Dexamethasone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7640	Formoterol, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, 12 Micrograms	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7641	Flunisolide, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7642	Glycopyrrolate, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7643	Glycopyrrolate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7645	Ipratropium Bromide, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7647	Isoetharine Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7650	Isoetharine Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram		12/1/2020	12/31/2999
J7657	Isoproterenol Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7660	Isoproterenol Hcl, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

J7667	Metaproterenol Sulfate, Inhalation Solution, Compounded Product, Concentrated Form, Per 10 Milligrams	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7670	Metaproterenol Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per 10 Milligrams	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).		12/31/2999
J7676	Pentamidine Isethionate, Inhalation Solution, Compounded Product, Administered	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7680	Terbutaline Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7681	Terbutaline Sulfate, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7683	Triamcinolone, Inhalation Solution, Compounded Product, Administered Through Dme, Concentrated Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7684	Triamcinolone, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per Milligram	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7685	Tobramycin, Inhalation Solution, Compounded Product, Administered Through Dme, Unit Dose Form, Per 300 Milligrams	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J9029	Intravesical Instillation, Nadofaragene Firadenovec-Vncg, Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9037	Injection, Belantamab Mafodontin-Blmf, 0.5 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9056	Injection, Bendamustine Hydrochloride (Vivimusta), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9057	Injection, Copanlisib, 1 Mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9058	Injection, Bendamustine Hydrochloride (Apotex), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J9059	Injection, Bendamustine Hydrochloride (Baxter), 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

J9063	Injection, Mirvetuximab Soravtansine-Gynx, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9247	Injection, Melphalan Flufenamide, 1Mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9259	Injection, Paclitaxel Protein-Bound Particles (American Regent), Not	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	Therapeutically Equivalent To J9264, 1 Mg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9274	Injection, Tebentafusp-Tebn, 1 Microgram	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9285	Injection, Olaratumab, 10 Mg	Non Covered: Procedure/service not covered by	9/1/2019	12/31/2999
		the Plan. Not subject to pre-service review.		
19286	Injection, Glofitamab-Gxbm, 2.5 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9313	Injection, Moxetumomab Pasudotox-Tdfk, 0.01 Mg	Non Covered: Procedure/service not covered by	4/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
9321	Injection, Epcoritamab-Bysp, 0.16 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9331	Injection, Sirolimus Protein-Bound Particles, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9332	Injection, Efgartigimod Alfa-Fcab, 2Mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	,,gg,g	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9333	Injection, Rozanolixizumab-Noli, 1 Mg	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
9334	Injection, Efgartigimod Alfa, 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	injection, Engantighned rima, Engrand rijalahermadee ame	Medical Policy Criteria. Submit for Recommended	., .,	1.2,0.1,2000
		Clinical Review to avoid post-service review.		
9347	Injection, Tremelimumab-Actl, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	ingesist, fromountained roas, ring	Medical Policy Criteria. Submit for Recommended	12020	12/01/2000
		Clinical Review to avoid post-service review.		
9350	Injection, Mosunetuzumab-Axgb, 1 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
0000	injosion, modulotazamab 70xgb, 1 mg	Medical Policy Criteria. Submit for Recommended	1, 1,2020	12/01/2000
		Clinical Review to avoid post-service review.		
9376	Injection, Pozelimab-Bbfg, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
0010	Injection, i ozeilinab-bbig, i wig	Medical Policy Criteria. Submit for Recommended	7/1/2024	12/01/2000
		Clinical Review to avoid post-service review.		
9380	Injection, Teclistamab-Cqyv, 0.5 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
9000	Injection, redistantab-oqyv, 0.5 ivig	Medical Policy Criteria. Submit for Recommended	11112023	12/31/2999
		Clinical Review to avoid post-service review.		
9381	Injection, Teplizumab-Mzwv, 5 Mcq	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
930 I	ппјесноп, терпzитпар-мzwv, э мсу		1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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J9600	Injection, Porfimer Sodium, 75 Mg	MP Criteria: Procedure/service reviewed against	9/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1/0000	0	Clinical Review to avoid post-service review.	0/45/0044	10/04/0000
K0002	Standard Hemi (Low Seat) Wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0003	Lightweight Wheelchair	MP Criteria: Procedure/service reviewed against	12/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0004	High Strength, Lightweight Wheelchair	MP Criteria: Procedure/service reviewed against	12/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed against	12/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0006	Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0007	Extra Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0008	Custom Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed against	4/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0009	Other Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
. 10000		Medical Policy Criteria. Submit for Recommended	0, 10, 2000	.=, = ., = = =
		Clinical Review to avoid post-service review.		
K0010	Standard - Weight Frame Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
110010	Startage Troight Famo Motorizour Tritodionali	Medical Policy Criteria. Submit for Recommended	0/10/2000	12/01/2000
		Clinical Review to avoid post-service review.		
K0011	Standard - Weight Frame Motorized/Power Wheelchair With Programmable	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10011	Control Parameters For Speed Adjustment, Tremor Dampening, Acceleration	Medical Policy Criteria. Submit for Recommended	112112003	12/01/2000
	Control And Braking	Clinical Review to avoid post-service review.		
K0012	Lightweight Portable Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
N0012	Lightweight Fortable Motorized/Fower Whitedichair	Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
		Clinical Review to avoid post-service review.		
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against	4/15/2016	12/31/2999
K0013	Custom Motorized/Power Whitelichair base	Medical Policy Criteria. Submit for Recommended	4/13/2010	12/31/2999
K0014	Other Motorized/Power Wheelchair Base	Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
NUU 14	Other Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against	1/2//2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
140050	Florestic or Foodbacks Additional Attention (Table 2) A. F. J.	Clinical Review to avoid post-service review.	0/45/0000	40/04/0000
K0053	Elevating Footrests, Articulating (Telescoping), Each	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0056		MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
	Lightweight, Or Ultralightweight Wheelchair	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

K0065	Spoke Protectors, Each	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0108	Wheelchair Component Or Accessory, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0455	Infusion Pump Used For Uninterrupted Parenteral Administration Of Medication,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	(E. G. , Epoprostenol Or Treprostinol)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0669	Seat/Back Custom; No Dme Pdac Ver	MP Criteria: Procedure/service reviewed against	9/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0743	Suction Pump, Home Model, Portable, For Use On Wounds	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0744	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable,	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
•	Pad Size 16 Square Inches Or Less	Medical Policy Criteria. Submit for Recommended		,
	. 44 5.25 10 5444.55.55 5. 2555	Clinical Review to avoid post-service review.		
0745	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable,	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
.07 10	Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square	Medical Policy Criteria. Submit for Recommended	0/ 1/2011	12/01/2000
	Inches	Clinical Review to avoid post-service review.		
0746	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable,	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
.07 40	Pad Size Greater Than 48 Square Inches	Medical Policy Criteria. Submit for Recommended	0/1/2011	12/01/2000
	ad olze oreater man 40 oquare mones	Clinical Review to avoid post-service review.		
(0800	Power Operated Vehicle, Group 1 Standard, Patient Weight Capacity Up To And	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	including 500 Founds	Clinical Review to avoid post-service review.		
(0801	Power Operated Vehicle, Group 1 Heavy Duty, Patient Weight Capacity, 301 To	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
(0001	450 Pounds	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	450 Founds	Clinical Review to avoid post-service review.		
(0802	Power Operated Vehicle, Group 1 Very Heavy Duty, Patient Weight Capacity 451	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10002	To 600 Pounds	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/3/1/2999
	10 000 Fourids	Clinical Review to avoid post-service review.		
(0806	Power Operated Vehicle, Group 2 Standard, Patient Weight Capacity Up To And	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	including 500 Pounds	Clinical Review to avoid post-service review.		
(0807	Power Operated Vehicle, Group 2 Heavy Duty, Patient Weight Capacity 301 To	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10007	450 Pounds	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	450 Pourius			
′0000	Power Operated Vehicle, Group 2 Very Heavy Duty, Patient Weight Capacity 451	Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
(0808		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	To 600 Pounds	Medical Policy Criteria. Submit for Recommended		
70040	December 1 Valida National Otherwise Objective	Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
(0812	Power Operated Vehicle, Not Otherwise Classified	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0813	Power Wheelchair, Group 1 Standard, Portable, Sling/Solid Seat And Back,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

K0814	Power Wheelchair, Group 1 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/27/2009	12/31/2999
		Clinical Review to avoid post-service review.		
K0815	Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		1-70 17-200
	outputs, of to the moleum good to an ad	Clinical Review to avoid post-service review.		
<0816	Power Wheelchair, Group 1 Standard, Captains Chair, Patient Weight Capactiy Up	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
110010	To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	107 tha modaling 000 F dands	Clinical Review to avoid post-service review.		
K0820	Power Wheelchair, Group 2 Standard, Portable, Sling/Solid Seat/Back, Patient	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10020	Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	Weight dapasity op 10 And moldding 500 Fodings	Clinical Review to avoid post-service review.		
K0821	Power Wheelchair, Group 2 Standard, Portable, Captains Chair, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10021	Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
	Capacity of 10 And including 300 Founds	1		
K0822	Power Wheelchair, Group 2 Standard, Sling/Solid Seat/Back, Patient Weight	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
NU022			1/21/2009	12/31/2999
	Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
140000		Clinical Review to avoid post-service review.	7/07/0000	10/01/0000
K0823	Power Wheelchair, Group 2 Standard, Captains Chair, Patient Weight Capacity Up	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<b>&lt;</b> 0824	Power Wheelchair, Group 2 Heavy Duty, Sling/Solid Seat/Back, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0825	Power Wheelchair, Group 2 Heavy Duty, Captains Chair, Patient Weight Capacity	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0826	Power Wheelchair, Group 2 Very Heavy Duty, Sling/Solid Seat/Back, Patient	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Weight Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0827	Power Wheelchair, Group 2 Very Heavy Duty, Captains Chair, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0828	Power Wheelchair, Group 2 Extra Heavy Duty, Sling/Solid Seat/Back, Patient	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Weight Capacity 601 Pounds Or More	Medical Policy Criteria. Submit for Recommended		
	The superstry contribution of more	Clinical Review to avoid post-service review.		
K0829	Power Wheelchair, Group 2 Extra Heavy Duty, Captains Chair, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10020	Capacity 601 Pounds Or More	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	Capacity 6011 curius of More	Clinical Review to avoid post-service review.		
K0830	Power Wheelchair, Group 2 Standard, Seat Elevator, Sling/Solid Seat/Back,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10000	Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	112112008	1213112333
	Fallent vveight Capacity Op 10 And including 300 Founds			
1/0004	Power Wheelchair, Group 2 Standard, Seat Elevator, Captains Chair, Patient	Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0831		MP Criteria: Procedure/service reviewed against	112112009	12/31/2999
	Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
·		Clinical Review to avoid post-service review.	7/07/0000	10/04/0000
K0835	Power Wheelchair, Group 2 Standard, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

K0836	Power Wheelchair, Group 2 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/27/2009	12/31/2999
		Clinical Review to avoid post-service review.		
(0837	Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0838	Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Captains Chair,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Patient Weight Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0839	Power Wheelchair, Group 2 Very Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		1-7-11-11-11
	Coarback, Fallont Wolght Capacity 101 10 000 Founds	Clinical Review to avoid post-service review.		
(0840	Power Wheelchair, Group 2 Extra Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
100-10	Seat/Back, Patient Weight Capacity 601 Pounds Or More	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	Cocarback, Fatterit Weight Oapacky 6011 ounds of Word	Clinical Review to avoid post-service review.		
(0841	Power Wheelchair, Group 2 Standard, Multiple Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
.0041	Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended	112112009	12/3/1/233
	Searback, Patient Weight Capacity Op 10 And including 500 Pounds			
(0842	Power Wheelchair, Group 2 Standard, Multiple Power Option, Captains Chair,	Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
.0842		MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
2010		Clinical Review to avoid post-service review.	7/07/0000	10/01/0000
0843	Power Wheelchair, Group 2 Heavy Duty, Multiple Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0848	Power Wheelchair, Group 3 Standard, Sling/Solid Seat/Back, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0849	Power Wheelchair, Group 3 Standard, Captains Chair, Patient Weight Capacity Up		7/27/2009	12/31/2999
	To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0850	Power Wheelchair, Group 3 Heavy Duty, Sling/Solid Seat/Back, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0851	Power Wheelchair, Group 3 Heavy Duty, Captains Chair, Patient Weight Capacity	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0852	Power Wheelchair, Group 3 Very Heavy Duty, Sling/Solid Seat/Back, Patient	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Weight Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		1-7-11-11-11
	Troight Supusity for 10 000 Founds	Clinical Review to avoid post-service review.		
0853	Power Wheelchair, Group 3 Very Heavy Duty, Captains Chair, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
.0000	Capacity, 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended	172172003	12/01/2000
	Capacity, 431 10 000 1 outlus	Clinical Review to avoid post-service review.		
K0854	Power Wheelchair, Group 3 Extra Heavy Duty, Sling/Solid Seat/Back, Patient	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
.0054		<u> </u>	112112009	12/3/1/2999
	Weight Capacity 601 Pounds Or More	Medical Policy Criteria. Submit for Recommended	1	
0055	December 11 Common O Francis II Common O Franc	Clinical Review to avoid post-service review.	7/07/0000	40/04/0000
0855	Power Wheelchair, Group 3 Extra Heavy Duty, Captains Chair, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Capacity 601 Pounds Or More	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

K0856	Power Wheelchair, Group 3 Standard, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
<b>&lt;</b> 0857	Power Wheelchair, Group 3 Standard, Single Power Option, Captains Chair,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0858	Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0859	Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Captains Chair,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	l attent Weight Capacity 301 10 4301 ounds	Clinical Review to avoid post-service review.		
(0860	Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10000		•	112112009	12/31/2999
	, , ,	Medical Policy Criteria. Submit for Recommended		
(0004		Clinical Review to avoid post-service review.	7/07/0000	40/04/0000
K0861		MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0862	Power Wheelchair, Group 3 Heavy Duty, Multiple Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0863	Power Wheelchair, Group 3 Very Heavy Duty, Multiple Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<0864	Power Wheelchair, Group 3 Extra Heavy Duty, Multiple Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
	3 1 7 3	Clinical Review to avoid post-service review.		
(0868	Power Wheelchair, Group 4 Standard, Sling/Solid Seat/Back, Patient Weight	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended	.,,_	.2/0 ./2000
		Clinical Review to avoid post-service review.		
K0869		MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10000		Medical Policy Criteria. Submit for Recommended	172172003	12/01/2000
		Clinical Review to avoid post-service review.		
(0870		MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
10070		Medical Policy Criteria. Submit for Recommended	112112009	12/31/2999
	Capacity 301 To 450 Pounds	•		
(0074	Decrease Miles and the first Consumer A Married Harrison Declared Children (Online of One of Declared	Clinical Review to avoid post-service review.	7/07/0000	40/04/0000
(0871		MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Weight Capacity 451 To 600 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0877	Power Wheelchair, Group 4 Standard, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0878	Power Wheelchair, Group 4 Standard, Single Power Option, Captains Chair,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
(0879	Power Wheelchair, Group 4 Heavy Duty, Single Power Option, Sling/Solid	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Seat/Back, Patient Weight Capacity 301 To 450 Pounds	Medical Policy Criteria. Submit for Recommended		

K0880	Power Wheelchair, Group 4 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight 451 To 600 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/27/2009	12/31/2999
K0884	Power Wheelchair, Group 4 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0885	Power Wheelchair, Group 4 Standard, Multiple Power Option, Captains Chair, Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
<b>&lt;</b> 0886	Power Wheelchair, Group 4 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0890	Power Wheelchair, Group 5 Pediatric, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0891	Power Wheelchair, Group 5 Pediatric, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0899	Power Mobile Device; No Dme Pdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K1004	Low Frequency Ultrasonic Diathermy Treatment Device For Home Use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
K1007	Bilateral Hip, Knee, Ankle, Foot Device, Powered, Includes Pelvic Component, Single Or Double Upright(S), Knee Joints Any Type, With Or Without Ankle Joints Any Type, Includes All Components And Accessories, Motors, Microprocessors, Sensors	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
K1027		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
K1030	External Recharging System For Battery (Internal) For Use With Implanted Cardiac Contractility Modulation Generator, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
K1034	Provision Of Covid-19 Test, Nonprescription Self-Administered And Self-Collected Use, Fda Approved, Authorized Or Cleared, One Test Count	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	5/12/2023	12/31/2999
K1035	Molecular Diagnostic Test Reader, Nonprescription Self-Administered And Self-Collected Use, Fda Approved, Authorized Or Cleared	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2023	12/31/2999
K1036	Supplies And Accessories (E.G., Transducer) For Low Frequency Ultrasonic Diathermy Treatment Device, Per Month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
K1037	Docking Station For Use With Oral Device/Appliance Used To Reduce Upper Airway Collapsibility	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
L0120	Cervical, Flexible, Non-Adjustable, Prefabricated, Off-The-Shelf (Foam Collar)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2015	12/31/2999

_1320	Thoracic, Pectus Carinatum Orthosis, Sternal Compression, Rigid Circumferential	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Frame With Anterior And Posterior Rigid Pads, Custom Fabricated	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_1834	Knee Orthosis, Without Knee Joint, Rigid, Custom-Fabricated	MP Criteria: Procedure/service reviewed against	10/1/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1840	Knee Orthosis, Derotation, Medial-Lateral, Anterior Cruciate Ligament, Custom	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Fabricated	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1844	Knee Orthosis, Single Upright, Thigh And Calf, With Adjustable Flexion And	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation Control,	Medical Policy Criteria. Submit for Recommended		
	With Or Without Varus/Valgus Adjustment, Custom Fabricated	Clinical Review to avoid post-service review.		
1846	Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation Control,	Medical Policy Criteria. Submit for Recommended		
	With Or Without Varus/Valgus Adjustment, Custom Fabricated	Clinical Review to avoid post-service review.		
1860	Knee Orthosis, Modification Of Supracondylar Prosthetic Socket, Custom-	MP Criteria: Procedure/service reviewed against	10/1/2008	12/31/2999
	Fabricated (Sk)	Medical Policy Criteria. Submit for Recommended	1 300	
		Clinical Review to avoid post-service review.		
2005	Knee Ankle Foot Orthosis, Any Material, Single Or Double Upright, Stance Control,	MP Criteria: Procedure/service reviewed against	9/1/2014	12/31/2999
	Automatic Lock And Swing Phase Release, Any Type Activation, Includes Ankle	Medical Policy Criteria. Submit for Recommended	0, 1,2011	, .,,
	Joint, Any Type, Custom Fabricated	Clinical Review to avoid post-service review.		
3001	Foot, Insert, Removable, Molded To Patient Model, Spenco, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Took, moork, removable, molacul for allerk model, openee, East	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3002	Foot, Insert, Removable, Molded To Patient Model, Plastazote Or Equal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
3002	1 oot, moon, romovable, molaca for allent model, radiazole of Equal, Easin	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3003	Foot, Insert, Removable, Molded To Patient Model, Silicone Gel, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
3000	1 oot, moort, removable, morace for attent model, officially cor, Each	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3010	Foot, Insert, Removable, Molded To Patient Model, Longitudinal Arch Support,	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
50.10	Each	the Plan. Not subject to pre-service review.	0/10/2001	12/01/2000
3020	Foot, Insert, Removable, Molded To Patient Model, Longitudinal/ Metatarsal	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
0020	Support, Each	the Plan. Not subject to pre-service review.	0/10/2001	12/01/2000
3030	Foot, Insert, Removable, Formed To Patient Foot, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
		the Plan. Not subject to pre-service review.	0, 10,200.	, 0 . , _ 0 0 0
3031	Foot, Insert/Plate, Removable, Addition To Lower Extremity Orthosis, High	Non Covered: Procedure/service not covered by	3/1/2009	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each	the Plan. Not subject to pre-service review.	0/1/2000	12/01/2000
3040	Foot, Arch Support, Removable, Premolded, Longitudinal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
,010	Took, 7 ton Support, Nomorabio, 1 Tomoraba, Longitadinai, Laon	the Plan. Not subject to pre-service review.	0/10/2001	12/01/2000
3050	Foot, Arch Support, Removable, Premolded, Metatarsal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
5000	1 oot, 7 ton oupport, Nomovable, 1 formolaed, Metatareal, Each	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3060	Foot, Arch Support, Removable, Premolded, Longitudinal/ Metatarsal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 oot, 7 ton oupport, Nomovable, 1 formolada, Longitaaliiai, Motataloai, Laon	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3070	Foot, Arch Support, Non-Removable Attached To Shoe, Longitudinal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
,0,0	Took, Alon oupport, Hon-Romovasio Attached To once, Longitudinal, Lach	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
_3080	Foot, Arch Support, Non-Removable Attached To Shoe, Metatarsal, Each	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
,,,,,	Took, Alon oupport, Hon-Romovable Attached To once, Metataloai, Lacif	the Plan. Not subject to pre-service review.	0/10/2007	12/01/2000
3090	Foot, Arch Support, Non-Removable Attached To Shoe, Longitudinal/Metatarsal,	Non Covered: Procedure/service not covered by	5/15/2007	12/31/2999
0030	Each	the Plan. Not subject to pre-service review.	3/13/2007	12/31/2999
3100	Hallus-Valgus Night Dynamic Splint, Prefabricated, Off-The-Shelf	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
100	Thailus-valgus Night Dynamic Splint, Prefabricated, Oil-The-Shell		1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		

		Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3150	Foot, Abduction Rotatation Bar, Without Shoes	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3160	Foot, Adjustable Shoe-Styled Positioning Device	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3170	Foot, Plastic, Silicone Or Equal, Heel Stabilizer, Prafabricated, Off-The-Shelf,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Each	the Plan. Not subject to pre-service review.		
3201	Orthopedic Shoe, Oxford With Supinator Or Pronator, Infant	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
.3202	Orthopedic Shoe, Oxford With Supinator Or Pronator, Child	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
.3203	Orthopedic Shoe, Oxford With Supinator Or Pronator, Junior	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3204	Orthopedic Shoe, Hightop With Supinator Or Pronator, Infant	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3206	Orthopedic Shoe, Hightop With Supinator Or Pronator, Child	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	, , <b>g</b>	the Plan. Not subject to pre-service review.		
3207	Orthopedic Shoe, Hightop With Supinator Or Pronator, Junior	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	The same street, and the same street of the same street, same	the Plan. Not subject to pre-service review.	., .,	, 0 1/2000
3212	Benesch Boot, Pair, Infant	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
0212	Borioson Boot, Full, Illiant	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
3213	Benesch Boot, Pair, Child	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
3213	Defleson boot, Fall, Offilia	the Plan. Not subject to pre-service review.	1/1/2000	12/3/1/2999
.3214	Benesch Boot, Pair, Junior	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
.3214	Beriesch Boot, Pair, Junior	,	1/1/2006	12/31/2999
.3215	Orthopedic Footwear, Ladies Shoe, Oxford, Each	the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
.3215	Orthopedic Footwear, Ladies Snoe, Oxford, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
0040	Orthonodic Footoors Lodico Obere Double lales Foot	the Plan. Not subject to pre-service review.	1/1/2006	40/04/0000
3216	Orthopedic Footwear, Ladies Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
221=		the Plan. Not subject to pre-service review.	44440000	10/01/0000
.3217	Orthopedic Footwear, Ladies Shoe, Hightop, Depth Inlay, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3219	Orthopedic Footwear, Mens Shoe, Oxford, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
.3221	Orthopedic Footwear, Mens Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3222	Orthopedic Footwear, Mens Shoe, Hightop, Depth Inlay, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
.3224	Orthopedic Footwear, Woman'S Shoe, Oxford, Used As An Integral Part Of A	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Brace (Orthosis)	the Plan. Not subject to pre-service review.		
.3225	Orthopedic Footwear, Man'S Shoe, Oxford, Used As An Integral Part Of A Brace	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	(Orthosis)	the Plan. Not subject to pre-service review.		
3230	Orthopedic Footwear, Custom Shoe, Depth Inlay, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	,,,,,,,,,,,	the Plan. Not subject to pre-service review.		
3250	Orthopedic Footwear, Custom Molded Shoe, Removable Inner Mold, Prosthetic	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Shoe, Each	the Plan. Not subject to pre-service review.	17 172000	12,01/2000
3251	Foot, Shoe Molded To Patient Model, Silicone Shoe, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
0201	Took, Shoo Molded To Fatient Model, Gilleone Onloo, Each	the Plan. Not subject to pre-service review.	1/1/2000	12/01/2009
.3252	Foot, Shoe Molded To Patient Model, Plastazote (Or Similar), Custom Fabricated,	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
JZJZ	proof, Shoe Molded to Patient Model, Plastazote (Or Similar), Custom Pabricated,	the Plan. Not subject to pre-service review.	1/1/2000	12/31/2999

L3253	Foot, Molded Shoe Plastazote (Or Similar) Custom Fitted, Each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
L3254	Non-Standard Size Or Width	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
-3234	Non-Standard Size Of Width	•	1/1/2000	12/31/2999
_3255	Non-Standard Size Or Length	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
_3233	Non-Standard Size Of Length	•	1/1/2000	12/31/2999
L3257	Orthopedic Footwear, Additional Charge For Split Size	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
L323 <i>1</i>	Offiopedic Footwear, Additional Charge For Split Size	the Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
L3265	Plastazote Sandal, Each	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
L3203	l lastazote Garidai, Lacii	the Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
L3300	Lift, Elevation, Heel, Tapered To Metatarsals, Per Inch	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20000	Ent, Elevation, Floor, rapered to Metatalouis, For mon	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3310	Lift, Elevation, Heel And Sole, Neoprene, Per Inch	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20010	Ent, Elevation, Floor and Colo, Floophene, For mon	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3320	Lift, Elevation, Heel And Sole, Cork, Per Inch	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20020	Ent, Elevation, Floor and Colo, Colin, For more	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3330	Lift, Elevation, Metal Extension (Skate)	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20000	Ent, Elovation, Motal Exterior (Ortate)	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3332	Lift, Elevation, Inside Shoe, Tapered, Up To One-Half Inch	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20002	Em, Elovation, molde ones, raporea, op 10 one han mon	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3334	Lift, Elevation, Heel, Per Inch	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
2000 .	Link, Elevation, Floor, For Mon	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3340	Heel Wedge, Sach	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	1.155. 1.75495, 5451.	the Plan. Not subject to pre-service review.	., .,	12/01/2000
L3350	Heel Wedge	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
20000	Thosa trougo	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
L3360	Sole Wedge, Outside Sole	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	Jose Trougo, Galeiao Goio	the Plan. Not subject to pre-service review.	., .,	12/01/2000
L3370	Sole Wedge, Between Sole	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3380	Clubfoot Wedge	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3390	Outflare Wedge	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3400	Metatarsal Bar Wedge, Rocker	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3410	Metatarsal Bar Wedge, Between Sole	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3420	Full Sole And Heel Wedge, Between Sole	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	3 ,	the Plan. Not subject to pre-service review.		
L3430	Heel, Counter, Plastic Reinforced	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
L3440	Heel, Counter, Leather Reinforced	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		
L3450	Heel, Sach Cushion Type	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		
L3455	Heel, New Leather, Standard	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	,	the Plan. Not subject to pre-service review.		,,
_3460	Heel, New Rubber, Standard	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	,	the Plan. Not subject to pre-service review.		

L3465	Heel, Thomas With Wedge	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3470	Heel, Thomas Extended To Ball	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3480	Heel, Pad And Depression For Spur	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3485	Heel, Pad, Removable For Spur	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3500	Orthopedic Shoe Addition, Insole, Leather	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3510	Orthopedic Shoe Addition, Insole, Rubber	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3520	Orthopedic Shoe Addition, Insole, Felt Covered With Leather	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3530	Orthopedic Shoe Addition, Sole, Half	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3540	Orthopedic Shoe Addition, Sole, Full	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		
3550	Orthopedic Shoe Addition, Toe Tap Standard	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
		the Plan. Not subject to pre-service review.		1-1-1-1-1-1
3560	Orthopedic Shoe Addition, Toe Tap, Horseshoe	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
	on the position of the property of the propert	the Plan. Not subject to pre-service review.	., .,	12/01/2000
3570	Orthopedic Shoe Addition, Special Extension To Instep (Leather With Eyelets)	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
,,,,	Orthopodic office / tadition, operation for motor (Education With Eyelete)	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
3580	Orthopedic Shoe Addition, Convert Instep To Velcro Closure	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
5000	Orthopodio Orioc / tadition, Convert mater 10 velore Globale	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
3590	Orthopedic Shoe Addition, Convert Firm Shoe Counter To Soft Counter	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Orthopodio Orioc Addition, Convert in in Orioc Counter to Cott Counter	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
3595	Orthopedic Shoe Addition, March Bar	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
5555	Orthopedic Office Addition, March Bai	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
3600	Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, Existing	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
3000	Transfer Of All Offices From One Since to Allother, Camper Frate, Existing	the Plan. Not subject to pre-service review.	1/1/2000	12/3/1/2999
3610	Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, New	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
5010	Transfer Of Air Orthosis From One Shoe To Another, Caliper Flate, New	the Plan. Not subject to pre-service review.	1/1/2000	12/3/1/2999
3620	Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, Existing	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
0020	Transfer Of All Offices From One Shoe to Another, Solid Stiffup, Existing	the Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
3630	Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, New	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
5030	Transfer Of All Offices From One Shoe to Allother, Solid Stirrup, New	•	1/1/2000	12/31/2999
3640	Transfer Of An Orthogic From One Chae To Another Dennis Browns Calint	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
3040	Transfer Of An Orthosis From One Shoe To Another, Dennis Browne Splint	· ·	1/1/2006	12/31/2999
2040	(Riveton), Both Shoes	the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
3649	Orthopedic Shoe, Modification, Addition Or Transfer, Not Otherwise Specified	Non Covered: Procedure/service not covered by	1/1/2006	12/31/2999
-0.4.0		the Plan. Not subject to pre-service review.	7/4/0007	40/04/0000
5610	Addition To Lower Extremity, Endoskeletal System, Above Knee, Hydracadence	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	System	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	
5611	Addition To Lower Extremity, Endoskeletal System, Above Knee - Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Disarticulation, 4 Bar Linkage, With Friction Swing Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5613	Addition To Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, With Hydraulic Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2007	12/31/2999
		Clinical Review to avoid post-service review.		
L5614	Addition To Lower Extremity, Exoskeletal System, Above Knee-Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Disarticulation, 4 Bar Linkage, With Pneumatic Swing Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5615	Addition, Endoskeletal Knee-Shin System, 4 Bar Linkage Or Multiaxial, Fluid	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Swing And Stance Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5616	Addition To Lower Extremity, Endoskeletal System, Above Knee, Universal	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Multiplex System, Friction Swing Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5620	Addition To Lower Extremity, Test Socket, Below Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	,, ,	Medical Policy Criteria. Submit for Recommended		1-7-3-1-2-3
		Clinical Review to avoid post-service review.		
_5624	Addition To Lower Extremity, Test Socket, Above Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	1.2,0.,2000
		Clinical Review to avoid post-service review.		
_5629	Addition To Lower Extremity, Below Knee, Acrylic Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
20020	Addition to Lower Extremity, Below Hiles, Herythe Gooder	Medical Policy Criteria. Submit for Recommended	17 172007	12/01/2000
		Clinical Review to avoid post-service review.		
_5631	Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Acrylic Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
_5001	Addition to Lower Extremity, Above trice of trice bisarticulation, Acrylle cocket	Medical Policy Criteria. Submit for Recommended	17172007	12/3 1/2333
		Clinical Review to avoid post-service review.		
L5638	Addition To Lower Extremity, Below Knee, Leather Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
L3030	Addition To Lower Extremity, Delow Milee, Leatiner Socket	Medical Policy Criteria. Submit for Recommended	77172007	12/31/2999
		Clinical Review to avoid post-service review.		
_5639	Addition To Lower Extremity, Below Knee, Wood Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
L3039	Addition to Lower Extremity, below Kilee, wood Socker	Medical Policy Criteria. Submit for Recommended	111/2001	12/3 1/2999
		1		
L5640	Addition To Lower Extremity, Knee Disarticulation, Leather Socket	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
L3040	Addition to Lower Extremity, whee Disarticulation, Leather Socket	Medical Policy Criteria. Submit for Recommended	77 172007	12/3 1/2999
		1		
_5642	Addition To Lower Extremity, Above Knee, Leather Socket	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
_3042	Addition To Lower Extremity, Above Knee, Leather Socket		7/1/2007	12/3 1/2999
		Medical Policy Criteria. Submit for Recommended		
FC44	Addition To Lower Extremity, Above Knee, Wood Socket	Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
_5644	Addition To Lower Extremity, Above Knee, Wood Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
5045	Addition To Lower Extremity, Below Knee, Flexible Inner Socket, External Frame	Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
_5645	Addition To Lower Extremity, Below Knee, Flexible Inner Socket, External Frame	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Addition To Lorent Education Below K. At El 11 O LO E. L. O. C.	Clinical Review to avoid post-service review.	7/4/0007	40/04/0000
_5646	Addition To Lower Extremity, Below Knee, Air, Fluid, Gel Or Equal, Cushion	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Socket	Medical Policy Criteria. Submit for Recommended		
	<u></u>	Clinical Review to avoid post-service review.		1010100000
_5647	Addition To Lower Extremity, Below Knee Suction Socket	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5648	Addition To Lower Extremity, Above Knee, Air, Fluid, Gel Or Equal, Cushion Socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2007	12/31/2999
		Clinical Review to avoid post-service review.		
L5651	Addition To Lower Extremity, Above Knee, Flexible Inner Socket, External Frame	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5652	Addition To Lower Extremity, Suction Suspension, Above Knee Or Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Disarticulation Socket	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
L5670	Addition To Lower Extremity, Below Knee, Molded Supracondylar Suspension	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	('Pts' Or Similar)	Medical Policy Criteria. Submit for Recommended	., ., = 0 0 .	1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	( to or omman)	Clinical Review to avoid post-service review.		
L5676	Additions To Lower Extremity, Below Knee, Knee Joints, Single Axis, Pair	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
L5704	Custom Shaped Protective Cover, Below Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Caston Shapour rototare Soron, Bolow Miles	Medical Policy Criteria. Submit for Recommended	1.7.7.2007	12/01/2000
		Clinical Review to avoid post-service review.		
-5705	Custom Shaped Protective Cover, Above Knee	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-0700	Outloth Chapea Hotelare Cover, Above Miles	Medical Policy Criteria. Submit for Recommended	17 172007	12/01/2000
		Clinical Review to avoid post-service review.		
5706	Custom Shaped Protective Cover, Knee Disarticulation	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-5700	Ouston Ghaped Frotective Gover, Nince Disarticulation	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
		Clinical Review to avoid post-service review.		
L5710	Addition, Exoskeletal Knee-Shin System, Single Axis, Manual Lock	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
L37 10	Addition, Exoskeletal Milee-Onlin System, Single Axis, Manda Lock	Medical Policy Criteria. Submit for Recommended	17172007	12/31/2999
		Clinical Review to avoid post-service review.		
_5711	Additions Exoskeletal Knee-Shin System, Single Axis, Manual Lock, Ultra-Light	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
_0/11	Material	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
	Waterial	Clinical Review to avoid post-service review.		
_5712	Addition, Exoskeletal Knee-Shin System, Single Axis, Friction Swing And Stance	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
LO7 12	Phase Control (Safety Knee)	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
	Thase Control (Calety Milee)	Clinical Review to avoid post-service review.		
_5714	Addition, Exoskeletal Knee-Shin System, Single Axis, Variable Friction Swing	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-07 14	Phase Control	Medical Policy Criteria. Submit for Recommended	17 172007	12/01/2000
	i nase condoi	Clinical Review to avoid post-service review.		
-5716	Addition, Exoskeletal Knee-Shin System, Polycentric, Mechanical Stance Phase	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-57 10	Lock	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
	LOCK	Clinical Review to avoid post-service review.		
<u>-</u> 5718	Addition, Exoskeletal Knee-Shin System, Polycentric, Friction Swing And Stance	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-07 10	Phase Control	Medical Policy Criteria. Submit for Recommended	11112001	12/3/1/2333
	I hase control			
-5722	Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-J1 ZZ	Stance Phase Control	ĕ	111/2001	12/31/2999
	Stance Phase Control	Medical Policy Criteria. Submit for Recommended		
E704	Addition Eventrelated Know Chin Customs Circula Avia Elizad Custom Discon Control	Clinical Review to avoid post-service review.	7/4/2007	10/01/0000
_5724	Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5726	Addition, Exoskeletal Knee-Shin System, Single Axis, External Joints Fluid Swing	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Phase Control	Medical Policy Criteria. Submit for Recommended		
5700		Clinical Review to avoid post-service review.	7/4/0007	40/04/0000
.5728	Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing And Stance	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5780	Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic/Hydra	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Pneumatic Swing Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<sub>-</sub> 5785	Addition, Exoskeletal System, Below Knee, Ultra-Light Material (Titanium, Carbon	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Fiber Or Equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5790	Addition, Exoskeletal System, Above Knee, Ultra-Light Material (Titanium, Carbon	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Fiber Or Equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<sub>-</sub> 5795	Addition, Exoskeletal System, Hip Disarticulation, Ultra-Light Material (Titanium,	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Carbon Fiber Or Equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5810	Addition, Endoskeletal Knee-Shin System, Single Axis, Manual Lock	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5811	Addition, Endoskeletal Knee-Shin System, Single Axis, Manual Lock, Ultra-Light	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
.0011	Material	Medical Policy Criteria. Submit for Recommended	17 172007	12/01/2000
	Waterial	Clinical Review to avoid post-service review.		
.5812	Addition, Endoskeletal Knee-Shin System, Single Axis, Friction Swing And Stance	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-3012	Phase Control (Safety Knee)	Medical Policy Criteria. Submit for Recommended	1/1/2007	12/3 1/2999
	Phase Control (Salety Knee)	•		
E011	Addition, Endoskeletal Knee-Shin System, Polycentric, Hydraulic Swing Phase	Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
.5814	Addition, Endoskeletal Knee-Snin System, Polycentric, Hydraulic Swing Phase	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Control, Mechanical Stance Phase Lock	Medical Policy Criteria. Submit for Recommended		
5010		Clinical Review to avoid post-service review.	=///000=	10/01/0000
.5816	Addition, Endoskeletal Knee-Shin System, Polycentric, Mechanical Stance Phase	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5818	Addition, Endoskeletal Knee-Shin System, Polycentric, Friction Swing, And Stance		7/1/2007	12/31/2999
	Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5822	Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Stance Phase Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5824	Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5826	Addition, Endoskeletal Knee-Shin System, Single Axis, Hydraulic Swing Phase	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
-	Control, With Miniature High Activity Frame	Medical Policy Criteria. Submit for Recommended	1	
	Table 1 and	Clinical Review to avoid post-service review.		
.5828	Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing And Stance	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
.0020	Phase Control	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
	Thase Cultur	1		
		Clinical Review to avoid post-service review.		

L5830	Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic/ Swing Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/1/2007	12/31/2999
	Control	Clinical Review to avoid post-service review.		
5840	Addition, Endoskeletal Knee/Shin System, 4-Bar Linkage Or Multiaxial, Pneumatic	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
.5040	Swing Phase Control	Medical Policy Criteria. Submit for Recommended	17172007	12/31/2999
	Swing Friase Control	Clinical Review to avoid post-service review.		
.5841	Addition, Endoskeletal Knee-Shin System, Polycentric, Pneumatic Swing, And	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
J04 I	Stance Phase Control	j e	4/1/2024	12/31/2999
	Stance Phase Control	Medical Policy Criteria. Submit for Recommended		
.5848	Addition To Endockeletal Knoo Chin Cystems Flyid Ctance Fytonsian Denomina	Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
.5848	Addition To Endoskeletal Knee-Shin System, Fluid Stance Extension, Dampening	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Feature, With Or Without Adjustability	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	5/45/0005	10/01/0000
.5856	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System,	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	Microprocessor Control Feature, Swing And Stance Phase, Includes Electronic	Medical Policy Criteria. Submit for Recommended		
	Sensor(S), Any Type	Clinical Review to avoid post-service review.		
.5857	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Microprocessor Control Feature, Swing Phase Only, Includes Electronic	Medical Policy Criteria. Submit for Recommended		
	Sensor(S), Any Type	Clinical Review to avoid post-service review.		
.5858	Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System,	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	Microprocessor Control Feature, Stance Phase Only, Includes Electronic	Medical Policy Criteria. Submit for Recommended		
	Sensor(S), Any Type	Clinical Review to avoid post-service review.		
5859	Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	Powered And Programmable Flexion/Extension Assist Control, Includes Any Type	Medical Policy Criteria. Submit for Recommended		
	Motor(S)	Clinical Review to avoid post-service review.		
5926	Addition To Lower Extremity Prosthesis, Endoskeletal, Knee Disarticulation, Above	MP Criteria: Procedure/service reviewed against	1/1/2024	12/31/2999
	Knee, Hip Disarticulation, Positional Rotation Unit, Any Type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.5961	Addition, Endoskeletal System, Polycentric Hip Joint, Pneumatic Or Hydraulic	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	Control, Rotation Control, With Or Without Flexion And/Or Extension Control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
5962	Addition, Endoskeletal System, Below Knee, Flexible Protective Outer Surface	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Covering System	Medical Policy Criteria. Submit for Recommended	.,,,	. =, 0 ., = 000
	overling eyelem	Clinical Review to avoid post-service review.		
5964	Addition, Endoskeletal System, Above Knee, Flexible Protective Outer Surface	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
.5504	Covering System	Medical Policy Criteria. Submit for Recommended	17172007	12/01/2000
	Covering System	Clinical Review to avoid post-service review.		
.5966	Addition, Endoskeletal System, Hip Disarticulation, Flexible Protective Outer	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
.5900	Surface Covering System	Medical Policy Criteria. Submit for Recommended	11112001	12/31/2999
	Surface Covering System	1		
T000	Addition To Leven Linch Drooth asia Multipuial Ankla With Coling Dhasa Astica	Clinical Review to avoid post-service review.	4/45/0045	40/04/0000
5968	Addition To Lower Limb Prosthesis, Multiaxial Ankle With Swing Phase Active	MP Criteria: Procedure/service reviewed against	4/15/2015	12/31/2999
	Dorsiflexion Feature	Medical Policy Criteria. Submit for Recommended		
5000		Clinical Review to avoid post-service review.	4/4/00/	10/04/0000
5969	Addition, Endoskeletal Ankle-Foot Or Ankle System, Power Assist, Includes Any	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	Type Motor(S)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	ļ	
.5970	All Lower Extremity Prostheses, Foot, External Keel, Sach Foot	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L5972	All Lower Extremity Prostheses, Foot, Flexible Keel	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended	.,.,	12/01/2000
		Clinical Review to avoid post-service review.		
L5973	Endoskeletal Ankle Foot System, Microprocessor Controlled Feature, Dorsiflexion	MP Criteria: Procedure/service reviewed against	11/15/2019	12/31/2999
	And/Or Plantar Flexion Control, Includes Power Source	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5974	All Lower Extremity Prostheses, Foot, Single Axis Ankle/Foot	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5976	All Lower Extremity Prostheses, Energy Storing Foot (Seattle Carbon Copy li Or	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5978	All Lower Extremity Prostheses, Foot, Multiaxial Ankle/Foot	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5979	All Lower Extremity Prosthesis, Multi-Axial Ankle, Dynamic Response Foot, One	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Piece System	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5980	All Lower Extremity Prostheses, Flex Foot System	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5981	All Lower Extremity Prostheses, Flex-Walk System Or Equal	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5982	All Exoskeletal Lower Extremity Prostheses, Axial Rotation Unit	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5984		MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
	Adjustability	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5985	All Endoskeletal Lower Extremity Prostheses, Dynamic Prosthetic Pylon	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5986	All Lower Extremity Prostheses, Multi-Axial Rotation Unit ('Mcp' Or Equal)	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5987		MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5991		EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
1.0000	Townson (Material Confedition 18) of the Book State	Coding Policy (CPCP).	4/4/0045	40/04/0000
L6026		MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
1 6611	Device, Excludes Terminal Device(S)  Addition To Upper Extremity Prosthesis, External Powered, Additional Switch, Any	MD Critorio, Dragoduro/ocridos residented accident	4/4/2000	10/01/0000
L6611		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
•	Туре	Medical Policy Criteria. Submit for Recommended		
	L	Clinical Review to avoid post-service review.		

<u>.</u> 6621	Upper Extremity Prosthesis Addition, Flexion/Extension Wrist With Or Without Friction, For Use With External Powered Terminal Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
	Friction, For Ose With External Powered Terminal Device	Clinical Review to avoid post-service review.		
6715	Terminal Device, Multiple Articulating Digit, Includes Motor(S), Initial Issue Or	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
7713	Replacement	Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
	Treplacement	Clinical Review to avoid post-service review.		
8880	Electric Hand, Switch Or Myolelectric Controlled, Independently Articulating Digits,	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
0000	Any Grasp Pattern Or Combination Of Grasp Patterns, Includes Motor(S)	Medical Policy Criteria. Submit for Recommended	1/1/2012	12/31/2999
	Any Grasp Fattern Of Combination Of Grasp Fatterns, includes woton(3)	•		
8882	Microprocessor Control Feature, Addition To Upper Limb Prosthetic Terminal	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
0002	Device	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
	Device	Clinical Review to avoid post-service review.		
920	Wrist Disarticulation, External Power, Self-Suspended Inner Socket, Removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
1920	Forearm Shell, Otto Bock Or Equal, Switch, Cables, Two Batteries And One	Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
	·			
925	Charger, Switch Control Of Terminal Device Wrist Disarticulation, External Power, Self-Suspended Inner Socket, Removable	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
1920	Forearm Shell, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One	ı	4/1/2009	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
930	Charger, Myoelectronic Control Of Terminal Device  Below Elbow, External Power, Self-Suspended Inner Socket, Removable Forearm	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
1930		Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
		•		
935	Control Of Terminal Device  Below Elbow, External Power, Self-Suspended Inner Socket, Removable Forearm	Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
935		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Shell, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger,	Medical Policy Criteria. Submit for Recommended		
20.40	Myoelectronic Control Of Terminal Device	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
940	Elbow Disarticulation, External Power, Molded Inner Socket, Removable Humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
20.45	Batteries And One Charger, Switch Control Of Terminal Device	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
945	Elbow Disarticulation, External Power, Molded Inner Socket, Removable Humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Shell, Outside Locking Hinges, Forearm, Otto Bock Or Equal Electrodes, Cables,	Medical Policy Criteria. Submit for Recommended		
	Two Batteries And One Charger, Myoelectronic Control Of Terminal Device	Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
6950	Above Elbow, External Power, Molded Inner Socket, Removable Humeral Shell,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Internal Locking Elbow, Forearm, Otto Bock Or Equal Switch, Cables, Two	Medical Policy Criteria. Submit for Recommended		
	Batteries And One Charger, Switch Control Of Terminal Device	Clinical Review to avoid post-service review.		
955	Above Elbow, External Power, Molded Inner Socket, Removable Humeral Shell,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Internal Locking Elbow, Forearm, Otto Bock Or Equal Electrodes, Cables, Two	Medical Policy Criteria. Submit for Recommended		
	Batteries And One Charger, Myoelectronic Control Of Terminal Device	Clinical Review to avoid post-service review.		
960	Shoulder Disarticulation, External Power, Molded Inner Socket, Removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch	Clinical Review to avoid post-service review.		
	Control Of Terminal Device			
965	Shoulder Disarticulation, External Power, Molded Inner Socket, Removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
	Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger,	Clinical Review to avoid post-service review.		
	Myoelectronic Control Of Terminal Device			
970	Interscapular-Thoracic, External Power, Molded Inner Socket, Removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm,	Medical Policy Criteria. Submit for Recommended	1	
	Otto Bock Or Equal Switch, Cables, Two Batteries And One Charger, Switch	Clinical Review to avoid post-service review.		
	Control Of Terminal Device			

L6975	Interscapular-Thoracic, External Power, Molded Inner Socket, Removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Shoulder Shell, Shoulder Bulkhead, Humeral Section, Mechanical Elbow, Forearm			
	Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger,	Clinical Review to avoid post-service review.		
	Myoelectronic Control Of Terminal Device	Cimical Notice at State poor Solition 1911		
_7007	Electric Hand, Switch Or Myoelectric Controlled, Adult	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7008	Electric Hand, Switch Or Myoelectric, Controlled, Pediatric	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7009	Electric Hook, Switch Or Myoelectric Controlled, Adult	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7040	Prehensile Actuator, Switch Controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7045	Electric Hook, Switch Or Myoelectric Ontrolled, Pediatric	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7170	Electronic Elbow, Hosmer Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7180	Electronic Elbow, Microprocessor Sequential Control Of Elbow And Terminal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Device	Medical Policy Criteria. Submit for Recommended		1-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
		Clinical Review to avoid post-service review.		
L7181	Electronic Elbow, Microprocessor Simultaneous Control Of Elbow And Terminal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Device	Medical Policy Criteria. Submit for Recommended	., ., _	12/01/2000
		Clinical Review to avoid post-service review.		
L7185	Electronic Elbow, Adolescent, Variety Village Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	The state of the s	Medical Policy Criteria. Submit for Recommended	., ., _	12/01/2000
		Clinical Review to avoid post-service review.		
L7186	Electronic Elbow, Child, Variety Village Or Equal, Switch Controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
_, .00		Medical Policy Criteria. Submit for Recommended	., ., _	12/01/2000
		Clinical Review to avoid post-service review.		
L7190	Electronic Elbow, Adolescent, Variety Village Or Equal, Myoelectronically	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
27 100	Controlled	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	Controlled	Clinical Review to avoid post-service review.		
L7191	Electronic Elbow, Child, Variety Village Or Equal, Myoelectronically Controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L7 10 1	Electronic Electry, orma, variety vinage or Equal, mysolocitomounty controlled	Medical Policy Criteria. Submit for Recommended	1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
_7259	Electronic Wrist Rotator, Any Type	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
_1_200	Libertonia Triber Notation, Piny Type	Medical Policy Criteria. Submit for Recommended	1, 1,2010	12/01/2000
		Clinical Review to avoid post-service review.		
L7360	Six Volt Battery, Each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
_1 300	OIN VOIL DAILETY, LACTI	Medical Policy Criteria. Submit for Recommended	7/1/2008	12/3/1/2333
		Clinical Review to avoid post-service review.		
L7362	Battery Charger, Six Volt, Each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L1 30Z	Dallery Charger, Six Volt, Each		4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

L7364	Twelve Volt Battery, Each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	Tworve voic Battery, East	Medical Policy Criteria. Submit for Recommended	4/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
7366	Battery Charger, Twelve Volt, Each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
000	James, James Jon, Lasin	Medical Policy Criteria. Submit for Recommended	., .,	1.270 172000
		Clinical Review to avoid post-service review.		
.7367	Lithium Ion Battery, Rechargeable, Replacement	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	3, 3	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7368	Lithium Ion Battery Charger, Replacement Only	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7900	Male Vacuum Erection System	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
7902	Tension Ring, For Vacuum Erection Device, Any Type, Replacement Only, Each	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8603	Injectable Bulking Agent, Collagen Implant, Urinary Tract, 2. 5 Ml Syringe, Includes	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	Shipping And Necessary Supplies	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
.8604	Injectable Bulking Agent, Dextranomer/Hyaluronic Acid Copolymer Implant,	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	Urinary Tract, 1 MI, Includes Shipping And Necessary Supplies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8605	Injectable Bulking Agent, Dextranomer/Hyaluronic Acid Copolymer Implant, Anal	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Canal, 1 Ml, Includes Shipping And Necessary Supplies	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
-8606	Injectable Bulking Agent, Synthetic Implant, Urinary Tract, 1 MI Syringe, Includes	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Shipping And Necessary Supplies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8607	Injectable Bulking Agent For Vocal Cord Medialization, 0.1 Ml, Includes Shipping	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	And Necessary Supplies	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8609	Artificial Cornea	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8612	Aqueous Shunt	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.8678	Electrical Stimulator Supplies (External) For Use With Implantable	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	Neurostimulator, Per Month	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
8679	Implantable Neurostimulator, Pulse Generator, Any Type	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
<sub>-</sub> 8680	Implantable Neurostimulator Electrode, Each	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

L8681	Patient Programmer (External) For Use With Implantable Programmable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Neurostimulator Pulse Generator, Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.8682	Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.8683	Radiofrequency Transmitter (External) For Use With Implantable Neurostimulator	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	Radiofrequency Receiver	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
.8685	Implantable Neurostimulator Pulse Generator, Single Array, Rechargeable,	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	Includes Extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8686	Implantable Neurostimulator Pulse Generator, Single Array, Non-Rechargeable,	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	Includes Extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8687	Implantable Neurostimulator Pulse Generator, Dual Array, Rechargeable, Includes	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	Extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8688	Implantable Neurostimulator Pulse Generator, Dual Array, Non-Rechargeable,	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	Includes Extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8689	External Recharging System For Battery (Internal) For Use With Implantable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	Neurostimulator, Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8694	Auditory Osseointegrated Device, Transducer/Actuator, Replacement Only, Each	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8695	External Recharging System For Battery (External) For Use With Implantable	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	Neurostimulator, Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8698	Miscellaneous Component, Supply Or Accessory For Use With Total Artificial	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	Heart System	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8701	Powered Upper Extremity Range Of Motion Assist Device, Elbow, Wrist, Hand	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	With Single Or Double Upright(S), Includes Microprocessor, Sensors, All	Medical Policy Criteria. Submit for Recommended		
	Components And Accessories, Custom Fabricated	Clinical Review to avoid post-service review.		
8702	Powered Upper Extremity Range Of Motion Assist Device, Elbow, Wrist, Hand,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	Finger, Single Or Double Upright(S), Includes Microprocessor, Sensors, All	Medical Policy Criteria. Submit for Recommended		
	Components And Accessories, Custom Fabricated	Clinical Review to avoid post-service review.		
И0001	Advancing Cancer Care Mips Value Pathways	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
Л0002	Optimal Care For Kidney Health Mips Value Pathways	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M0003	Optimal Care For Patients With Episodic Neurological Conditions Mips Value	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Pathways	the Plan. Not subject to pre-service review.		
Л0004	Supportive Care For Neurodegenerative Conditions Mips Value Pathways	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		
M0005	Value In Primary Care Mips Value Pathway	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		

M0075	Cellular Therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
M0100	Intragastric Hypothermia Using Gastric Freezing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
M0240	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring, Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0241	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring In The Home Or Residence, This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency, Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0243	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0244	Intravenous Infusion Or Subcutaneous Injection, Casirivimab And Imdevimab Includes Infusion Or Injection, And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0245	Intravenous Infusion, Bamlanivimab And Etesevimab, Includes Infusion And Post Administration Monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0246	Intravenous Infusion, Bamlanivimab And Etesevimab, Includes Infusion And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider Based To The Hospital During The Covid 19 Public Health Emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	12/31/2999
M0300	Iv Chelation Therapy (Chemical Endarterectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
M1150	Left Ventricular Ejection Fraction (Lvef) Less Than Or Equal To 40% Or Documentation Of Moderately Or Severely Depressed Left Ventricular Systolic Function	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1151	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1152	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1153	Patient With Diagnosis Of Osteoporosis On Date Of Encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
И1154	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1155	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine Any Time During Or Before The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999

M1159	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1160	Patient Had Anaphylaxis Due To The Meningococcal Vaccine Any Time On Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Before The Patient'S 13Th Birthday	the Plan. Not subject to pre-service review.	., ., 2020	1270172000
W1161	Patient Had Anaphylaxis Due To The Tetanus, Diphtheria Or Pertussis Vaccine	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Any Time On Or Before The Patient'S 13Th Birthday	the Plan. Not subject to pre-service review.	17 172020	12/01/2000
M1162	Patient Had Encephalitis Due To The Tetanus, Diphtheria Or Pertussis Vaccine	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Any Time On Or Before The Patient'S 13Th Birthday	the Plan. Not subject to pre-service review.	17 172020	12/01/2000
M1163	Patient Had Anaphylaxis Due To The Hpv Vaccine Any Time On Or Before The	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Patient'S 13Th Birthday	the Plan. Not subject to pre-service review.	., ., 2020	1270172000
M1164		Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Of The Measurement Period	the Plan. Not subject to pre-service review.		
Л1165	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	,gg	the Plan. Not subject to pre-service review.		1-1-1-1-1-1
M1166	Pathology Report For Tissue Specimens Produced From Wide Local Excisions Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Re-Excisions	the Plan. Not subject to pre-service review.		
И1167	In Hospice Or Using Hospice Services During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		1-1-1-1-1-1
M1168	Patient Received An Influenza Vaccine On Or Between July 1 Of The Year Prior	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	To The Measurement Period And June 30 Of The Measurement Period	the Plan. Not subject to pre-service review.		1-1-1-1-1-1
M1169	Documentation Of Medical Reason(S) For Not Administering Influenza Vaccine	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(E.G., Prior Anaphylaxis Due To The Influenza Vaccine)	the Plan. Not subject to pre-service review.		1-1-1-1-1-1
M1170	Patient Did Not Receive An Influenza Vaccine On Or Between July 1 Of The Year	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Prior To The Measurement Period And June 30 Of The Measurement Period	the Plan. Not subject to pre-service review.		
V1171	Patient Received At Least One Td Vaccine Or One Tdap Vaccine Between Nine	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Years Prior To The Encounter And The End Of The Measurement Period	the Plan. Not subject to pre-service review.		1-1-1-1-1-1
M1172	Documentation Of Medical Reason(S) For Not Administering Td Or Tdap Vaccine	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(E.G., Prior Anaphylaxis Due To The Td Or Tdap Vaccine Or History Of	the Plan. Not subject to pre-service review.		
	Encephalopathy Within Seven Days After A Previous Dose Of A Td-Containing	, '		
	Vaccine)			
M1173	Patient Did Not Receive At Least One Td Vaccine Or One Tdap Vaccine Between	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Nine Years Prior To The Encounter And The End Of The Measurement Period	the Plan. Not subject to pre-service review.		
M1174	Patient Received At Least Two Doses Of The Herpes Zoster Recombinant	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th	the Plan. Not subject to pre-service review.		
	Birthday Before Or During The Measurement Period			
M1175	Documentation Of Medical Reason(S) For Not Administering Zoster Vaccine (E.G.,	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Prior Anaphylaxis Due To The Zoster Vaccine)	the Plan. Not subject to pre-service review.		
M1176	Patient Did Not Receive At Least Two Doses Of The Herpes Zoster Recombinant	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th	the Plan. Not subject to pre-service review.		
	Birthday Before Or During The Measurement Period			
M1177	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	After Their 60Th Birthday And Before The End Of The Measurement Period	the Plan. Not subject to pre-service review.		
<i>I</i> 1178	Documentation Of Medical Reason(S) For Not Administering Pneumococcal	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Vaccine (E.G., Prior Anaphylaxis Due To The Pneumococcal Vaccine)	the Plan. Not subject to pre-service review.		
Л1179	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Vaccine, On Or After Their 60Th Birthday And Before Or During Measurement	the Plan. Not subject to pre-service review.		
	Period			
<i>I</i> 1180	Patients On Immune Checkpoint Inhibitor Therapy	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		

M1181	Grade 2 Or Above Diarrhea And/Or Grade 2 Or Above Colitis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1182	Patients Not Eligible Due To Pre-Existing Inflammatory Bowel Disease (Ibd) (E.G.,	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
WITTOE	Ulcerative Colitis, Crohn'S Disease)	the Plan. Not subject to pre-service review.	17 172023	12/01/2000
M1183	Documentation Of Immune Checkpoint Inhibitor Therapy Held And Corticosteroids	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Or Immunosuppressants Prescribed Or Administered	the Plan. Not subject to pre-service review.		1-1-1-1-1-1-1
M1184	Documentation Of Medical Reason(S) For Not Prescribing Or Administering	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Corticosteroid Or Immunosuppressant Treatment (E.G., Allergy, Intolerance,	the Plan. Not subject to pre-service review.		1-1-1-1-1-1-1
	Infectious Etiology, Pancreatic Insufficiency, Hyperthyroidism, Prior Bowel Surgical			
	Interventions, Celiac Disease, Receiving Other Medication, Awaiting Diagnostic			
	Workup Results For Alternative Etiologies, Other Medical			
	Reasons/Contraindication)			
M1185	Documentation Of Immune Checkpoint Inhibitor Therapy Not Held And/Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Corticosteroids Or Immunosuppressants Prescribed Or Administered Was Not	the Plan. Not subject to pre-service review.		
	Performed, Reason Not Given			
M1186	Patients Who Have An Order For Or Are Receiving Hospice Or Palliative Care	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M1187	Patients With A Diagnosis Of End Stage Renal Disease (Esrd)	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M1188	Patients With A Diagnosis Of Chronic Kidney Disease (Ckd) Stage 5	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M1189	Documentation Of A Kidney Health Evaluation Defined By An Estimated	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr)	the Plan. Not subject to pre-service review.		
	Performed	, '		
M1190	Documentation Of A Kidney Health Evaluation Was Not Performed Or Defined By	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	An Estimated Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio	the Plan. Not subject to pre-service review.		
	(Uacr)	, '		
M1191	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M1192	Patients With An Existing Diagnosis Of Squamous Cell Carcinoma Of The	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Esophagus	the Plan. Not subject to pre-service review.		
M1193	Surgical Pathology Reports That Contain Impression Or Conclusion Of Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Recommendation For Testing Of Mmr By Immunohistochemistry, Msi By Dna-	the Plan. Not subject to pre-service review.		
	Based Testing Status, Or Both			
M1194	Documentation Of Medical Reason(S) Surgical Pathology Reports Did Not Contain	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By	the Plan. Not subject to pre-service review.		
	Immunohistochemistry, Msi By Dna-Based Testing Status, Or Both Tests Were			
	Not Included (E.G., Patient Will Not Be Treated With Checkpoint Inhibitor Therapy,			
	No Residual Carcinoma Is Present In The Sample [Tissue Exhausted Or Status			
	Post Neoadjuvant Treatment], Insufficient Tumor For Testing)			
M1195	Surgical Pathology Reports That Do Not Contain Impression Or Conclusion Of Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Recommendation For Testing Of Mmr By Immunohistochemistry, Msi By Dna-	the Plan. Not subject to pre-service review.		
	Based Testing Status, Or Both, Reason Not Given			
M1196	Initial (Index Visit) Numeric Rating Scale (Nrs), Visual Rating Scale (Vrs), Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Itchyquant Assessment Score Of Greater Than Or Equal To 4	the Plan. Not subject to pre-service review.		
M1197	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(Index) Assessment Score To The Follow-Up Visit Score	the Plan. Not subject to pre-service review.		
M1198	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not	the Plan. Not subject to pre-service review.		
	Completed During The Follow-Up Encounter			

M1199	Patients Receiving Rrt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2023	12/31/2999
M1200	Ace Inhibitor (Ace-I) Or Arb Therapy Prescribed During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
		the Plan. Not subject to pre-service review.		
M1201	Documentation Of Medical Reason(S) For Not Prescribing Ace Inhibitor (Ace-I) Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Arb Therapy During The Measurement Period (E.G., Pregnancy, History Of	the Plan. Not subject to pre-service review.		
	Angioedema To Ace-I, Other Allergy To Ace-I And Arb, Hyperkalemia Or History	, '		
	Of Hyperkalemia While On Ace-I Or Arb Therapy, Acute Kidney Injury Due To Ace-			
	I Or Arb Therapy), Other Medical Reasons)			
M1202	Documentation Of Patient Reason(S) For Not Prescribing Ace Inhibitor Or Arb	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Therapy During The Measurement Period, (E.G., Patient Declined, Other Patient	the Plan. Not subject to pre-service review.		
	Reasons)	, '		
M1203	Ace Inhibitor Or Arb Therapy Not Prescribed During The Measurement Period,	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Reason Not Given	the Plan. Not subject to pre-service review.		
M1204	Initial (Index Visit) Numeric Rating Scale (Nrs), Visual Rating Scale (Vrs), Or	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Itchyquant Assessment Score Of Greater Than Or Equal To 4	the Plan. Not subject to pre-service review.		
M1205	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(Index) Assessment Score To The Follow-Up Visit Score	the Plan. Not subject to pre-service review.		
M1206	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not	the Plan. Not subject to pre-service review.		
	Completed During The Follow-Up Encounter			
M1207	Patient Is Screened For Food Insecurity, Housing Instability, Transportation	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	Needs, Utility Difficulties, And Interpersonal Safety	the Plan. Not subject to pre-service review.	.,.,2020	.2,01,2000
M1208	Patient Is Not Screened For Food Insecurity, Housing Instability, Transportation	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
200	Needs, Utility Difficulties, And Interpersonal Safety	the Plan. Not subject to pre-service review.	.,.,2020	.2,01,2000
M1209	At Least Two Orders For High-Risk Medications From The Same Drug Class,	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(Table 4), Without Appropriate Diagnoses	the Plan. Not subject to pre-service review.	., .,	.2,01,2000
M1210	At Least Two Orders For High-Risk Medications From The Same Drug Class,	Non Covered: Procedure/service not covered by	1/1/2023	12/31/2999
	(Table 4), Not Ordered	the Plan. Not subject to pre-service review.	1,	
M1211	Most Recent Hemoglobin A1C Level > 9.0%	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	11100   1000   1110   1100   1	the Plan. Not subject to pre-service review.	.,.,_0	.2,01,2000
M1212	Hemoglobin A1C Level Is Missing, Or Was Not Performed During The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Measurement Period (12 Months)	the Plan. Not subject to pre-service review.	., .,	.2,01,2000
M1213	No History Of Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc <	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
2.10	70%) And Present Spirometry Is >= 70%	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1214	Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Documented And Reviewed	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1215	Documentation Of Medical Reason(S) For Not Documenting And Reviewing	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Spirometry Results (E.G., Patients With Dementia Or Tracheostomy)	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1216	No Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
W11210	Documented And/Or No Spirometry Performed With Results Documented During	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
	The Encounter	The Flan. Not subject to pre-service review.		
M1217	Documentation Of System Reason(S) For Not Documenting And Reviewing	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VI 12 11	Spirometry Results (E.G., Spirometry Equipment Not Available At The Time Of	the Plan. Not subject to pre-service review.	1/1/2024	12/3/1/2000
	The Encounter)	The Flan. Not subject to pre-service review.		
M1218	Patient Has Copd Symptoms (E.G., Dyspnea, Cough/Sputum, Wheezing)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VI 12 10	Talient has copa symptoms (E.G., Dysphea, Cough/Spatiam, Wheezing)	the Plan. Not subject to pre-service review.	1/1/2024	12/3/1/2999
M1219	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VI IZ I J	Anaphysians Due to the vaccine on or before the Date of the Elicounter	the Plan. Not subject to pre-service review.	1/1/2024	12/3/1/2999

M1220	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; With Evidence Of Retinopathy	the Plan. Not subject to pre-service review.		
Л1221	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; Without Evidence Of Retinopathy			
И1222	Glaucoma Plan Of Care Not Documented, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11000	OL BLOCO B	the Plan. Not subject to pre-service review.	4/4/0004	40/04/0000
M1223	Glaucoma Plan Of Care Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
И1224	Intraocular Pressure (Iop) Reduced By A Value Less Than 20% From The Pre- Intervention Level	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1225	Intraocular Pressure (Iop) Reduced By A Value Of Greater Than Or Equal To 20% From The Pre-Intervention Level	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1226	lop Measurement Not Documented, Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1227	Evidence-Based Therapy Was Prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1228	Patient, Who Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia, Has Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1229	Patient, Who Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia, Is Referred Within 1 Month Of The Reactive Hcv Antibody Test To A Clinician Who Treats Hcv Infection	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1230	Patient Has A Reactive Hcv Antibody Test And Does Not Have A Follow Up Hcv Viral Test, Or Patient Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Detects Hcv Viremia And Is Not Referred To A Clinician Who Treats Hcv Infection Within 1 Month And Does Not Have Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
И1231	Patient Receives Hcv Antibody Test With Nonreactive Result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1232	Patient Receives Hcv Antibody Test With Reactive Result	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1233	Patient Does Not Receive Hcv Antibody Test Or Patient Does Receive Hcv Antibody Test But Results Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1234	Patient Has A Reactive Hcv Antibody Test, And Has A Follow Up Hcv Viral Test That Does Not Detect Hcv Viremia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1235	Documentation Or Patient Report Of Hcv Antibody Test Or Hcv Rna Test Which Occurred Prior To The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1236	Baseline Mrs > 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1237	Patient Reason For Not Screening For Food Insecurity, Housing Instability, Transportation Needs, Utility Difficulties, And Interpersonal Safety (E.G., Patient Declined Or Other Patient Reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1238	Documentation That Administration Of Second Recombinant Zoster Vaccine Could Not Occur During The Performance Period Due To The Recommended 2-6 Month Interval Between Doses (I.E, First Dose Received After October 31)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1239	Patient Did Not Respond To The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999

M1240	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
	The state of the s	The real rest caspect to proceed to the rest.		
V1241	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Saw Me As A Person, Not Just Someone With A Medical Problem	the Plan. Not subject to pre-service review.		
M1242		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Understood What Is Important To Me In My Life	the Plan. Not subject to pre-service review.		
M1243	Patient Provided A Response Other Than Completely True For The Question Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Patient Felt Heard And Understood By This Provider And Team	the Plan. Not subject to pre-service review.		
M1244	Patient Provided A Response Other Than Completely True For The Question Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Patient Felt This Provider And Team Put My Best Interests First When Making	the Plan. Not subject to pre-service review.		
	Recommendations About My Care	, ,		
M1245	Patient Provided A Response Other Than Completely True For The Question Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Patient Felt This Provider And Team Saw Me As A Person, Not Just Someone	the Plan. Not subject to pre-service review.		
	With A Medical Problem	, ,		
M1246	Patient Provided A Response Other Than Completely True For The Question Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Patient Felt This Provider And Team Understood What Is Important To Me In My	the Plan. Not subject to pre-service review.		
	Life			
M1247	Patient Responded Completely True For The Question Of Patient Felt This	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Provider And Team Put My Best Interests First When Making Recommendations	the Plan. Not subject to pre-service review.		
	About My Care			
M1248	Patient Responded Completely True For The Question Of Patient Felt This	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Provider And Team Saw Me As A Person, Not Just Someone With A Medical	the Plan. Not subject to pre-service review.		
	Problem	, i		
M1249	Patient Responded Completely True For The Question Of Patient Felt This	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Provider And Team Understood What Is Important To Me In My Life	the Plan. Not subject to pre-service review.		
M1250	Patient Responded As Completely True For The Question Of Patient Felt Heard	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	And Understood By This Provider And Team	the Plan. Not subject to pre-service review.		
M1251	Patients For Whom A Proxy Completed The Entire Hu Survey On Their Behalf For	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Any Reason (No Patient Involvement)	the Plan. Not subject to pre-service review.		
M1252	Patients Who Did Not Complete At Least One Of The Four Patient Experience Hu	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Survey Items And Return The Hu Survey Within 60 Days Of The Ambulatory	the Plan. Not subject to pre-service review.		
	Palliative Care Visit			
M1253	Patients Who Respond On The Patient Experience Hu Survey That They Did Not	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Receive Care By The Listed Ambulatory Palliative Care Provider In The Last 60	the Plan. Not subject to pre-service review.		
	Days (Disavowal)			
M1254	Patients Who Were Deceased When The Hu Survey Reached Them	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1255	Patients Who Have Another Reason For Visiting The Clinic [Not Prenatal Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Postpartum Care] And Have A Positive Pregnancy Test But Have Not Established	the Plan. Not subject to pre-service review.		
	The Clinic As An Ob Provider (E.G., Plan To Terminate The Pregnancy Or Seek			
	Prenatal Services Elsewhere)			
M1256	Prior History Of Known Cvd	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1257	Cvd Risk Assessment Not Performed Or Incomplete (E.G., Cvd Risk Assessment	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Was Not Documented), Reason Not Otherwise Specified	the Plan. Not subject to pre-service review.		
M1258	Cvd Risk Assessment Performed, Have A Documented Calculated Risk Score	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1259	Patients Listed On The Kidney-Pancreas Transplant Waitlist Or Who Received A	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Living Donor Transplant Within The First Year Following Initiation Of Dialysis	the Plan. Not subject to pre-service review.		

И1260	Patients Who Were Not Listed On The Kidney-Pancreas Transplant Waitlist Or Patients Who Did Not Receive A Living Donor Transplant Within The First Year	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
	Following Initiation Of Dialysis	The Flan. Not subject to pre-service review.		
11261		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Of Dialysis	the Plan. Not subject to pre-service review.		
1262	Patients Who Had A Transplant Prior To Initiation Of Dialysis	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11263	Patients In Hospice On Their Initiation Of Dialysis Date Or During The Month Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Evaluation	the Plan. Not subject to pre-service review.		
11264	Patients Age 75 Or Older On Their Initiation Of Dialysis Date	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11265	Cms Medical Evidence Form 2728 For Dialysis Patients: Initial Form Completed	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11266	Patients Admitted To A Skilled Nursing Facility (Snf)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11267	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist Or Is Not In	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The	the Plan. Not subject to pre-service review.		
	Last Day Of Each Month During The Measurement Period			
11268	Patients On Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	As Of The Last Day Of Each Month During The Measurement Period	the Plan. Not subject to pre-service review.		
1269	Receiving Esrd Mcp Dialysis Services By The Provider On The Last Day Of The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Reporting Month	the Plan. Not subject to pre-service review.		
1270	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Last Day Of Each Month During The Measurement Period	the Plan. Not subject to pre-service review.		
11271	Patients With Dementia At Any Time Prior To Or During The Month	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11272	Patients On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Day Of Each Month During The Measurement Period	the Plan. Not subject to pre-service review.		
11273	Patients Who Were Admitted To A Skilled Nursing Facility (Snf) Within One Year	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Of Dialysis Initiation According To The Cms-2728 Form	the Plan. Not subject to pre-service review.		
11274		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Of Evaluation Were Excluded From That Month	the Plan. Not subject to pre-service review.		
11275	Patients Determined To Be In Hospice Were Excluded From Month Of Evaluation	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	And The Remainder Of Reporting Period	the Plan. Not subject to pre-service review.		
1276	Bmi Documented Outside Normal Parameters, No Follow-Up Plan Documented,	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	No Reason Given	the Plan. Not subject to pre-service review.		
1277	Colorectal Cancer Screening Results Documented And Reviewed	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11278	Elevated Or Hypertensive Blood Pressure Reading Documented, And The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Indicated Follow-Up Is Documented	the Plan. Not subject to pre-service review.		
1279	Elevated Or Hypertensive Blood Pressure Reading Documented, Indicated Follow-	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Up Not Documented, Reason Not Given	the Plan. Not subject to pre-service review.		
1280	Women Who Had A Bilateral Mastectomy Or Who Have A History Of A Bilateral	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Mastectomy Or For Whom There Is Evidence Of A Right And A Left Unilateral	the Plan. Not subject to pre-service review.		
	Mastectomy			
1281	Blood Pressure Reading Not Documented, Reason Not Given	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
1282	Patient Screened For Tobacco Use And Identified As A Tobacco Non-User	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		

M1283	Patient Screened For Tobacco Use And Identified As A Tobacco User	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1284	Patients Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long Term Care With Pos Code 32, 33, 34, 54, Or 56 For More Than 90		1/1/2024	12/31/2999
	Consecutive Days During The Measurement Period			
M1285	Screening, Diagnostic, Film, Digital Or Digital Breast Tomosynthesis (3D)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Mammography Results Were Not Documented And Reviewed, Reason Not Otherwise Specified	the Plan. Not subject to pre-service review.		
И1286	Bmi Is Documented As Being Outside Of Normal Parameters, Follow-Up Plan Is Not Completed For Documented Medical Reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
И1287	Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is Documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1288	Documented Reason For Not Screening Or Recommending A Follow-Up For High Blood Pressure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1289	Patient Identified As Tobacco User Did Not Receive Tobacco Cessation	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	the Plan. Not subject to pre-service review.		
M1290	Patient Not Eligible Due To Active Diagnosis Of Hypertension	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1291	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	the Plan. Not subject to pre-service review.	1	
M1292	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
	With A Diagnosis Of Advanced Illness Or Two Outpatient, Observation, Ed Or	, '		
	Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced			
	Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period			
M1293	Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Documented	the Plan. Not subject to pre-service review.		
M1294	Normal Blood Pressure Reading Documented, Follow-Up Not Required	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1295	Patients With A Diagnosis Or Past History Of Total Colectomy Or Colorectal	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Cancer	the Plan. Not subject to pre-service review.		
M1296	Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Required	the Plan. Not subject to pre-service review.		
M1297	Bmi Not Documented Due To Medical Reason Or Patient Refusal Of Height Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Weight Measurement	the Plan. Not subject to pre-service review.	4/4/0004	10/01/0000
M1298	Documentation Of Patient Pregnancy Anytime During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11000	Prior To And Including The Current Encounter	the Plan. Not subject to pre-service review.	11110001	10/01/0000
M1299	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
14000	Influence Incoming the March Influence Influen	the Plan. Not subject to pre-service review.	4/4/0004	40/04/0000
M1300	Influenza Immunization Was Not Administered For Reasons Documented By	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Clinician (E.G., Patient Allergy Or Other Medical Reasons, Patient Declined Or	the Plan. Not subject to pre-service review.		
11001	Other Patient Reasons, Vaccine Not Available Or Other System Reasons)	N 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4/4/0004	40/04/0000
M1301	Patient Identified As A Tobacco User Received Tobacco Cessation Intervention	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	During The Measurement Period Or In The Six Months Prior To The Measurement	the Plan. Not subject to pre-service review.		
	Period (Counseling And/Or Pharmacotherapy)			

M1302	Screening, Diagnostic, Film Digital Or Digital Breast Tomosynthesis (3D)	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Mammography Results Documented And Reviewed	the Plan. Not subject to pre-service review.		
M1303	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
И1304		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	On Or After Their 19Th Birthday And Before The End Of The Measurement Period	the Plan. Not subject to pre-service review.		
M1305	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	After Their 19Th Birthday And Before The End Of The Measurement Period	the Plan. Not subject to pre-service review.		
И1306		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Before The Measurement Period	the Plan. Not subject to pre-service review.		
И1307	Documentation Stating The Patient Has Received Or Is Currently Receiving	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Palliative Or Hospice Care	the Plan. Not subject to pre-service review.		1
M1308	Influenza Immunization Was Not Administered, Reason Not Given	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.	., ., _ 0	12,01,2000
M1309	Palliative Care Services Provided To Patient Any Time During The Measurement	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Period	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
M1310		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VITOTO		the Plan. Not subject to pre-service review.	1/1/2024	12/3 1/2333
	Period (Counseling, Pharmacotherapy, Or Both), If Identified As A Tobacco User	line Flan. Not subject to pre-service review.		
	Period (Couriseling, Pharmacotherapy, Or Both), it identified As A Tobacco Oser			
M1311	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1312	Patient Not Screened For Tobacco Use	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1313	Tobacco Screening Not Performed Or Tobacco Cessation Intervention Not	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Provided During The Measurement Period Or In The Six Months Prior To The	the Plan. Not subject to pre-service review.		
	Measurement Period			
M1314	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		1-7-3-11-2-3-3
M1315	Colorectal Cancer Screening Results Were Not Documented And Reviewed;	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Reason Not Otherwise Specified	the Plan. Not subject to pre-service review.	., ., _ 0	12,01,2000
M1316	Current Tobacco Non-User	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
WITOTO	Guildin 1684666 Noil 6361	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
M1317	Patients Who Are Counseled On Connection With A Csp And Explicitly Opt Out	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VITOTI	Tationts with Are obtained on conficultin with A osp And Explicitly Opt Out	the Plan. Not subject to pre-service review.	1/1/2024	12/3 1/2333
M1318	Patients Who Did Not Have Documented Contact With A Csp For At Least One Of	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VIIJIO		the Plan. Not subject to pre-service review.	1/1/2024	12/3 1/2999
		The Plan. Not subject to pre-service review.		
M1319	That There Was No Contact With A Csp Patients Who Had Documented Contact With A Csp For At Least One Of Their	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
VI 13 19	· · · · · · · · · · · · · · · · · · ·	•	1/1/2024	12/31/2999
14000	Screened Positive Hrsns Within 60 Days After Screening	the Plan. Not subject to pre-service review.	4/4/0004	40/04/0000
И1320	Patients Who Screened Positive For At Least 1 Of The 5 Hrsns	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
14004	Deficiely Miss Mars Not Company of the Table 1 The Deficiency of the	the Plan. Not subject to pre-service review.	4/4/0004	40/04/0000
M1321	· · · · · · · · · · · · · · · · · · ·	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Follow Up Or Who Did Not Have A Documented lop Or No Plan Of Care	the Plan. Not subject to pre-service review.		
	Documented If The lop Was >25 Mm Hg			1212100000
M1322	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	For Elevated Intraocular Pressure (lop) With Tonometry With Documented lop	the Plan. Not subject to pre-service review.		
	=<25 Mm Hg For Injected Eye			

M1323	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened		1/1/2024	12/31/2999
	For Elevated Intraocular Pressure (Iop) With Tonometry With Documented Iop >25	the Plan. Not subject to pre-service review.		
	Mm Hg And A Plan Of Care Was Documented			
Л1324	Patients Who Had An Intravitreal Or Periocular Corticosteroid Injection (E.G.,	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Triamcinolone, Preservative-Free Triamcinolone, Dexamethasone,	the Plan. Not subject to pre-service review.		
	Dexamethasone Intravitreal Implant, Or Fluocinolone Intravitreal Implant)			
Л1325	Patients Who Were Not Seen For Reasons Documented By Clinician For Patient	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Or Medical Reasons (E.G., Inadequate Time For Follow-Up, Patients Who	the Plan. Not subject to pre-service review.		
	Received A Prior Intravitreal Or Periocular Steroid Injection Within The Last Six (6)			
	Months And Had A Subsequent lop Evaluation With lop <25Mm Hg Within Seven			
	(7) Weeks Of Treatment)			
<i>I</i> 1326	Patients With A Diagnosis Of Hypotony	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
Л1327	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Who Were Not Re-Evaluated Within 8 Weeks	the Plan. Not subject to pre-service review.		
Л1328	Patients With A Diagnosis Of Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1329	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	2 Weeks Before The Initial Encounter Or 8 Weeks After Initial Acute Pvd	the Plan. Not subject to pre-service review.		
	Encounter			
M1330	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G.,	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Inadequate Time For Follow Up)	the Plan. Not subject to pre-service review.		
Л1331	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Evaluated No Later Than 8 Weeks From Initial Exam	the Plan. Not subject to pre-service review.		
M1332	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Who Were Not Re-Evaluated Within 2 Weeks	the Plan. Not subject to pre-service review.		
M1333	Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
M1334	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	2 Weeks Before The Initial Encounter Or 2 Weeks After Initial Acute Pvd	the Plan. Not subject to pre-service review.		
	Encounter			
M1335	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G.,	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Inadequate Time For Follow Up)	the Plan. Not subject to pre-service review.		
Л1336	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Evaluated No Later Than 2 Weeks	the Plan. Not subject to pre-service review.		
Л1337	Acute Pvd	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
Л1338	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
	Functioning Scores During The Performance Period	, '		
11339	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Assessment Who Demonstrated Positive Improvement Or Maintenance Of	the Plan. Not subject to pre-service review.		
	Functioning Scores During The Performance Period	, '		
11340	Index Assessment Completed Using The 12-Item Whodas 2.0 Or Sds During The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Denominator Identification Period	the Plan. Not subject to pre-service review.		
11341	Patients Who Did Not Have A Follow-Up Assessment Or Did Not Have An	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Assessment Within 30 To 180 Days After The Index Assessment During The	the Plan. Not subject to pre-service review.		
	Performance Period			
11342	Patients Who Died During The Performance Period	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.	., .,	,,

M1343		Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Extreme Straight Line Response Sets On The Pam	the Plan. Not subject to pre-service review.		
11344	Patients Who Did Not Have A Baseline Pam Score And/Or A Second Score Within	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	6 To 12 Month Of Baseline Pam Score	the Plan. Not subject to pre-service review.		
1345	Patients Who Had A Baseline Pam Score And A Second Score Within 6 To 12	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Month Of Baseline Pam Score	the Plan. Not subject to pre-service review.		
1346	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 6 Points	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Within A 6 To 12 Month Period	the Plan. Not subject to pre-service review.		
11347	Patients Who Achieved A Net Increase In Pam Score Of At Least 3 Points In A 6	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	To 12 Month Period (Passing)	the Plan. Not subject to pre-service review.	., ., _ 0	12/01/2000
11348	Patients Who Achieved A Net Increase In Pam Score Of At Least 6-Points In A 6	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	To 12 Month Period (Excellent)	the Plan. Not subject to pre-service review.	., ., _ 0	12/01/2000
11349	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 3 Points	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
10-10	Within 6 To 12 Month Period	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
11350	Patients Who Had A Completed Suicide Safety Plan Initiated, Reviewed Or	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
1330			1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11351	The Index Clinical Encounter Patients Who Had A Suicide Safety Plan Initiated, Reviewed, Or Updated And	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11331		,	1/1/2024	12/31/2999
	Reviewed And Updated In Collaboration With The Patient And Their Clinician	the Plan. Not subject to pre-service review.		
	Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After			
	Initiation Control of the Control of		11110001	10/01/0000
11352	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs Or Equivalent		1/1/2024	12/31/2999
	Assessment	the Plan. Not subject to pre-service review.		
11353	Patients Who Did Not Have A Completed Suicide Safety Plan Initiated, Reviewed	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
	Of The Index Clinical Encounter			
11354	Patients Who Did Not Have A Suicide Safety Plan Initiated, Reviewed, Or Updated	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Or Reviewed And Updated In Collaboration With The Patient And Their Clinician	the Plan. Not subject to pre-service review.		
	Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After			
	Initiation			
11355	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
11356	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	· ·	the Plan. Not subject to pre-service review.		
11357	Patients Who Had A Reduction In Suicidal Ideation And/Or Behavior Upon Follow-	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Up Assessment Within 120 Days Of Index Assessment	the Plan. Not subject to pre-service review.		1
11358	Patients Who Did Not Have A Reduction In Suicidal Ideation And/Or Behavior	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Upon Follow-Up Assessment Within 120 Days Of Index Assessment	the Plan. Not subject to pre-service review.	17 17202 1	12/01/2000
11359	Index Assessment During The Denominator Period When The Suicidal Ideation	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.	17 172024	12/01/2000
	Occurs And A Non-Zero C-Ssrs Score Is Obtained	The Flam. 140t subject to pre-service review.		
1360	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
1300	Sulcidal Ideation And/Or Behavior Symptoms based On The C-Ssis		1/1/2024	12/3 1/2999
1361	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
11301	Suicide Risk Dased On Their Clinician S Evaluation Of A Clinician-Rated 1001	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
14000	D.C. ( NW. D. ID. ). T. M.	the Plan. Not subject to pre-service review.	4/4/0004	10/04/2222
11362	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
1363	Patients Who Did Not Have A Follow-Up Assessment Within 120 Days Of The	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Index Assessment	the Plan. Not subject to pre-service review.		

M1364	Calculated 10-Year Ascvd Risk Score Of >= 20 Percent During The Performance Period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1365	Patient Encounter During The Performance Period With Hospice And Palliative	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11000	Care Specialty Code 17	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1366	Focusing On Women'S Health Mips Value Pathway	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11000	1 codding on women or reduct without activity	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
И1367	Quality Care For The Treatment Of Ear, Nose, And Throat Disorders Mips Value	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11007	Pathway	the Plan. Not subject to pre-service review.	17 172024	12/01/2000
M1368	Prevention And Treatment Of Infectious Disorders Including Hepatitis C And Hiv	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
11000	Mips Value Pathway	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1369	Quality Care In Mental Health And Substance Use Disorders Mips Value Pathway	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Quality Galo III Montai Floatai 7 tha Gastanoo Goo Biograpio Impo Valuo 1 atimay	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
M1370	Rehabilitative Support For Musculoskeletal Care Mips Value Pathway	Non Covered: Procedure/service not covered by	1/1/2024	12/31/2999
	Trondsmaarro Support of Museumentellotal Sure Impervalue Fallmay	the Plan. Not subject to pre-service review.	17 172021	12/01/2000
2031	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
2001	Train 7 than york (Exchang 7 thousand)	Medical Policy Criteria. Submit for Recommended	0/2 1/2012	12/01/2000
		Clinical Review to avoid post-service review.		
P9020	Platelet Rich Plasma, Each Unit	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
0020	natolot Mon nasma, Each onit	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
20035	Cardiokymography	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
20000	Cardiokymography	the Plan. Not subject to pre-service review.	1/1/1930	12/3/1/2999
Q0114	Fern Test	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
Q011 <del>4</del>	i dii rest	the Plan. Not subject to pre-service review.	1/1/1930	12/3/1/2999
Q0115	Post-Coital Direct, Qualitative Examinations Of Vaginal Or Cervical Mucous	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
20113	1 OSI-COILAI DIFECI, QUAINATIVE EXAMINIATIONS OF VAGINAL OF CERVICAL MUCCUS	the Plan. Not subject to pre-service review.	1/1/1930	12/3/1/2999
20240	Injection, Casirivimab And Imdevimab, 600 Mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
20240	Injection, Casilivillab And Indevillab, 600 Mg	Not subject to pre-service review. Check EIU	0/1/2023	12/3/1/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q0243	Injection, Casirivimab And Imdevimab, 2400 Mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
30240	injection, Casilivillab And inidevillab, 2400 Mg	Not subject to pre-service review. Check EIU	0/1/2023	12/3/1/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
20244	Injection, Casirivimab And Imdevimab, 1200 Mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
X0277	injection, desirvinas And indevinas, 1200 Mg	Not subject to pre-service review. Check EIU	0/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
20245	Injection, Bamlanivimab And Etesevimab, 2100 Mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	12/31/2999
20243	Injection, Balmanivillab And Etesevillab, 2100 Mg	Not subject to pre-service review. Check EIU	0/1/2023	12/3/1/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q0477	Power Module Patient Cable For Use With Electric Or Electric/Pneumatic	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
x∪ <del>+</del> 111		<u> </u>	1/ 1/2010	12/3/1/2999
	Ventricular Assist Device, Replacement Only	Medical Policy Criteria. Submit for Recommended		
20470	Douge Adoptor For Llog With Floatric Or Floatric/Phogmatic Vantricular Assist	Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
20478	Power Adapter For Use With Electric Or Electric/Pneumatic Ventricular Assist	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
	Device, Vehicle Type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Q0479	Power Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	1/1/2011	12/31/2999
Q0480	Driver For Use With Pneumatic Ventricular Assist Device, Replacement Only	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0481	Microprocessor Control Unit For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0482	Microprocessor Control Unit For Use With Electric/Pneumatic Combination Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0483	Monitor/Display Module For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0484	Monitor/Display Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0485	Monitor Control Cable For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0486	Monitor Control Cable For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0487	Leads (Pneumatic/Electrical) For Use With Any Type Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0488	Power Pack Base For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0489	Power Pack Base For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0490	Emergency Power Source For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0491	Emergency Power Source For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0492	Emergency Power Supply Cable For Use With Electric Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0493	Emergency Power Supply Cable For Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0494	Emergency Hand Pump For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999

Q0495	Battery/Power Pack Charger For Use With Electric Or Electric/Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/27/2009	12/31/2999
	Total and Alexander De Troop, Troop and all the Stray	Clinical Review to avoid post-service review.		
20496	Battery, Other Than Lithium-Ion, For Use With Electric Or Electric/Pneumatic	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
20.00	Ventricular Assist Device, Replacement Only	Medical Policy Criteria. Submit for Recommended	1,21,2000	12/01/2000
	Volidiodiai 7.0000 Bovioo, Ropidoonioni Only	Clinical Review to avoid post-service review.		
Q0497	Battery Clips For Use With Electric Or Electric/Pneumatic Ventricular Assist	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
Q0 101	Device, Replacement Only	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	Bevice, replacement only	Clinical Review to avoid post-service review.		
Q0498	Holster For Use With Electric Or Electric/Pneumatic Ventricular Assist Device,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
<b>Q</b> 0-100	Replacement Only	Medical Policy Criteria. Submit for Recommended	172172000	12/01/2000
	replacement only	Clinical Review to avoid post-service review.		
Q0499	Belt/Vest/Bag For Use To Carry External Peripheral Components Of Any Type	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
30700	Ventricular Assist Device, Replacement Only	Medical Policy Criteria. Submit for Recommended	172172003	12/01/2000
	Vehilloulal Assist Device, Neplacement Only	,		
Q0500	Filters For Use With Electric Or Electric/Pneumatic Ventricular Assist Device,	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
20000	·	· ·	1/21/2009	12/31/2999
	Replacement Only	Medical Policy Criteria. Submit for Recommended		
2224		Clinical Review to avoid post-service review.	= 10=10000	10/01/0000
Q0501	Shower Cover For Use With Electric Or Electric/Pneumatic Ventricular Assist	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Device, Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0502	Mobility Cart For Pneumatic Ventricular Assist Device, Replacement Only	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0503	Battery For Pneumatic Ventricular Assist Device, Replacement Only, Each	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0504	Power Adapter For Pneumatic Ventricular Assist Device, Replacement Only,	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Vehicle Type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0506	Battery, Lithium-Ion, For Use With Electric Or Electric/Pneumatic Ventricular	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	Assist Device, Replacement Only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q0507	Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist	MP Criteria: Procedure/service reviewed against	4/1/2013	12/31/2999
	Device	Medical Policy Criteria. Submit for Recommended		
	201100	Clinical Review to avoid post-service review.		
20516	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved	Non Covered: Procedure/service not covered by	1/2/2024	12/31/2999
20010	Prescription Oral Drug, Per 30-Days	the Plan. Not subject to pre-service review.	1/2/2024	12/01/2000
20517	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved	Non Covered: Procedure/service not covered by	1/2/2024	12/31/2999
20317	, ,,,,	the Plan. Not subject to pre-service review.	1/2/2024	12/31/2999
Q0518	Prescription Oral Drug, Per 60-Days  Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved	Non Covered: Procedure/service not covered by	1/2/2024	12/31/2999
30518		•	1/2/2024	12/31/2999
20540	Prescription Oral Drug, Per 90-Days	the Plan. Not subject to pre-service review.	0/45/0004	40/04/0000
Q0519	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved	Non Covered: Procedure/service not covered by	9/15/2024	12/31/2999
	Prescription Injectable Drug, Per 30-Days	the Plan. Not subject to pre-service review.		
Q0520	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved	Non Covered: Procedure/service not covered by	9/15/2024	12/31/2999
	Prescription Injectable Drug, Per 60-Days	the Plan. Not subject to pre-service review.		
Q2026	Injection, Radiesse, 0.1 MI	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Q2028	Injection, Sculptra, 0.5 Mg	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q2041	Axicabtagene Ciloleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive	MP Criteria: Procedure/service reviewed against	4/1/2018	12/31/2999
	Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per	Medical Policy Criteria. Submit for Recommended		
	Therapeutic Dose	Clinical Review to avoid post-service review.		
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 Mg	Non Covered: Procedure/service not covered by	4/1/2024	12/31/2999
		the Plan. Not subject to pre-service review.		
Q2052	Services, Supplies, And Accessories Used In The Home For The Administration	Non Covered: Procedure/service not covered by	4/1/2014	12/31/2999
	Of Intravenous Immune Globulin (Ivig)	the Plan. Not subject to pre-service review.		
Q2053	Brexucabtagene Autoleucel, Up To 200 Million Autologous Anti-Cd19 Car Positive	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per	Medical Policy Criteria. Submit for Recommended		
	Therapeutic Dose	Clinical Review to avoid post-service review.		
Q2054	Lisocabtagene Maraleucel, Up To 110 Million Autologous Anti-Cd19 Car-Positive	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	Viable T Cells, Including Leukapheresis And Dose Preparation Procedures, Per	Medical Policy Criteria. Submit for Recommended		
	Therapeutic Dose	Clinical Review to avoid post-service review.		
Q2055	Idecabtagene Vicleucel, Up To 510 Million Autologous B-Cell Maturation Antigen	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(Bcma) Directed Car-Positive T Cells, Including Leukapheresis And Dose	Medical Policy Criteria. Submit for Recommended		
	Preparation Procedures, Per Therapeutic Dose	Clinical Review to avoid post-service review.		
Q2056	Ciltacabtagene Autoleucel, Up To 100 Million Autologous B-Cell Maturation	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	Antigen (Bcma) Directed Car-Positive T Cells, Including Leukapheresis And Dose	Medical Policy Criteria. Submit for Recommended		
	Preparation Procedures, Per Therapeutic Dose	Clinical Review to avoid post-service review.		
Q4082	Drug Or Biological, Not Otherwise Classified, Part B Drug Competitive Acquisition	Non Covered: Procedure/service not covered by	1/1/2007	12/31/2999
	Program (Cap)	the Plan. Not subject to pre-service review.		
Q4100	Skin Substitute, Not Otherwise Specified	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4101	Apligraf, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4102	Oasis Wound Matrix, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4103	Oasis Burn Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4104	Integra Bilayer Matrix Wound Dressing (Bmwd), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4105	Integra Dermal Regeneration Template (Drt) Or Integra Omnigraft Dermal	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	Regeneration Matrix, Per Square Centimeter	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4106	Dermagraft, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4107	Graftjacket, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		l

Q4108	Integra Matrix, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.11.10		Clinical Review to avoid post-service review.	=/4=/0004	10/01/0000
Q4110	Primatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
Q4111	Gammagraft, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
Q4111	Ganinagran, Fer Square Centiliteter	Not subject to pre-service review. Check EIU	5/15/2021	12/31/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4112	Cymetra, Injectable, 1Cc	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	5,, .,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4113	Graftjacket Xpress, Injectable, 1Cc	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4114	Integra Flowable Wound Matrix, Injectable, 1Cc	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4115	Alloskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
Q4116	Alloderm, Per Square Centimeter	Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
Q4110	Allouerin, Fer Square Centimeter	Medical Policy Criteria. Submit for Recommended	2/1/2021	12/31/2999
		Clinical Review to avoid post-service review.		
Q4117	Hyalomatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
<b>Q</b>	Tryalomatin, For Equato Committee	Not subject to pre-service review. Check EIU	0,10,2021	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4118	Matristem Micromatrix, 1 Mg	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4121	Theraskin, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.1100		Clinical Review to avoid post-service review.	40/45/0004	10/01/0000
Q4122	Dermacell, Dermacell Awm Or Dermacell Awm Porous, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	10/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
Q4123	Alloskin Rt, Per Square Centimeter	Clinical Review to avoid post-service review.  EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
Q4 123	Alloskiii Ki, Fei Squale Gentiinletei	Not subject to pre-service review. Check EIU	3/13/2021	12/31/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
		Todaling Folicy (GFGF).		

Q4124	Oasis Ultra Tri-Layer Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
(4125	Arthroflex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4126	Memoderm, Dermaspan, Tranzgraft Or Integuply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4127	Talymed, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4128	Flex Hd, Or Allopatch Hd, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4130	Strattice Tm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4132	Grafix Core And Grafixpl Core, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	8/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4133	Grafix Prime, Grafixpl Prime, Stravix And Stravixpl, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	8/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4134	Hmatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4135	Mediskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
24400		Coding Policy (CPCP).	=//=/000/	10/01/0000
Q4136	Ez-Derm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
24407		Coding Policy (CPCP).	0/4/0004	10/04/0000
Q4137	Amnioexcel, Amnioexcel Plus Or Biodexcel, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
24420	Diadforce Durfley, Day Course Confirmator	Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
Q4138	Biodfence Dryflex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4139	Amniomatrix Or Biodmatrix, Injectable, 1 Cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4140	Biodfence, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4141	Alloskin Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4142	Xcm Biologic Tissue Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4143	Repriza, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4145	Epifix, Injectable, 1 Mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4146	Tensix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4147	Architect, Architect Px, Or Architect Fx, Extracellular Matrix, Per Square	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Centimeter	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4148	Neox Cord 1K, Neox Cord Rt, Or Clarix Cord 1K, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4149	Excellagen, 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4150	Allowrap Ds Or Dry, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4151	Amnioband Or Guardian, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	8/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	]	

Q4152	Dermapure, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/1	15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4153	Dermavest And Plurivest, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/	2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4154	Biovance, Per Square Centimeter		1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4155	Neoxflo Or Clarixflo, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. 12/	2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4156	Neox 100 Or Clarix 100, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/	2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4157	Revitalon, Per Square Centimeter		2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4158	Kerecis Omega3, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/1	15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4159	Affinity, Per Square Centimeter		1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
4160	Nushield, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/	2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4161	Bio-Connekt Wound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/1	15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4162	Woundex Flow, Bioskin Flow, 0.5 Cc		2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4163	Woundex, Bioskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/	2/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
4164	Helicoll, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/1	15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4165	Keramatrix Or Kerasorb, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
Q+100	Troiding of Troidsons, 1 of Oquare Continuous	Not subject to pre-service review. Check EIU	12/01/2000
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4166	Cytal, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4167	Truskin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4168	Amnioband, 1 Mg	MP Criteria: Procedure/service reviewed against 8/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended	
		Clinical Review to avoid post-service review.	
Q4169	Artacent Wound, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4170	Cygnus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
Q4171	Intent I A Ma	Coding Policy (CPCP).	12/31/2999
Q4171	Interfyl, 1 Mg	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4173	Palingen Or Palingen Xplus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
Q4173	allinger of Fallinger Apius, Fer oquare certainleter	Not subject to pre-service review. Check EIU	12/31/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4174	Palingen Or Promatrx, 0.36 Mg Per 0.25 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4175	Miroderm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4176	Neopatch Or Therion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4177	Floweramnioflo, 0.1 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4178	Floweramniopatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Toword Interpretation, Total Square Container	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4179	Flowerderm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	, ' '	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4180	Revita, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4181	Amnio Wound, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4182	Transcyte, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4183	Surgigraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4184	Cellesta Or Cellesta Duo, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
0.4405	0    1    5    1    4    (05    4    5    0    0	Coding Policy (CPCP).	40/4/0000	10/04/0000
Q4185	Cellesta Flowable Amnion (25 Mg Per Cc); Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
04400	Frifix Day Carrena Combination	Coding Policy (CPCP).  MP Criteria: Procedure/service reviewed against 7	7/1/2020	12/31/2999
Q4186	Epifix, Per Square Centimeter	Medical Policy Criteria. Submit for Recommended	7/1/2020	12/31/2999
		Clinical Review to avoid post-service review.		
Q4187	Epicord, Per Square Centimeter		7/1/2020	12/31/2999
Q4101	Epicord, Fer Square Certifficier	Medical Policy Criteria. Submit for Recommended	11112020	12/31/2999
		Clinical Review to avoid post-service review.		
Q4188	Amnioarmor, Per Square Centimeter		12/1/2020	12/31/2999
Q+100	Annioannor, i ei oquare oentimeter	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4189	Artacent Ac, 1 Mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4190	Artacent Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4191	Restorigin, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4192	Restorigin, 1 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4193	Coll-E-Derm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4194	Novachor, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4195	Puraply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4196	Puraply Am, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4197	Puraply Xt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4198	Genesis Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4199	Cygnus Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.1000		Coding Policy (CPCP).	10/01/0000
Q4200	Skin Te, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.100.1		Coding Policy (CPCP).	10/04/0000
Q4201	Matrion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4000	(0.50/0.) 40	Coding Policy (CPCP).	40/04/2222
Q4202	Keroxx (2.5G/Cc), 1Cc	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4203	Derma-Gide, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4204	Xwrap, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4205	Membrane Graft Or Membrane Wrap, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4206	Fluid Flow Or Fluid Gf, 1 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4208	Novafix, Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4209	Surgraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4211	Amnion Bio Or Axobiomembrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4040	latt. B. O	Coding Policy (CPCP).	10/04/0000
Q4212	Allogen, Per Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04040	Accept O.F.Mar	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
Q4213	Ascent, 0.5 Mg		12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
Q4214	Cellesta Cord, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
Q42 14	Cellesta Cord, Per Square Cellumeter	Not subject to pre-service review. Check EIU	12/3/1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4215	Axolotl Ambient Or Axolotl Cryo, 0.1 Mg	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
QTZ IU	ANOIGH AMBIETH OF ANOIGH OTYO, U. I WIG	Not subject to pre-service review. Check EIU	12/3/1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4216	Artacent Cord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
Q72 IU	Artabelli Obiu, i el oquale Ochililletel	Not subject to pre-service review. Check EIU	12/3/1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4217	Woundfix, Biowound, Woundfix Plus, Biowound Plus, Woundfix Xplus Or	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Biowound Xplus, Per Square Centimeter	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4218	Surgicord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4219	Surgigraft-Dual, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4220	Bellacell Hd Or Surederm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4221	Amniowrap2, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4222	Progenamatrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		1-1-1-1
Q4224	Human Health Factor 10 Amniotic Patch (Hhf10-P), Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
0.4005	Association (On Demonstrial TI, Demonstrial Times (On the other	Coding Policy (CPCP).	4/4/0000	40/04/0000
Q4225	Amniobind Or Dermabind TI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
Q4226	Myown Skin, Includes Harvesting And Preparation Procedures, Per Square	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
Q4220	Centimeter	Not subject to pre-service review. Check EIU	10/1/2024	12/31/2999
	Centimeter	policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4227	Amniocore, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
Q+ZZ1	7 tillinocolo, i ol oqualo collamotol	Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4229	Cogenex Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
0	2-3-1017 minusia manusiana, i ai aquana continuotor	Not subject to pre-service review. Check EIU		12,0 ,, 2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4230	Cogenex Flowable Amnion, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	3	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4231	Corplex P, Per Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4232	Corplex, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4233	Surfactor Or Nudyn, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4234	Xcellerate, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.100=		Coding Policy (CPCP).	10/04/0000
Q4235	Amniorepair Or Altiply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
Q4236	Carepatch, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
J4230	Carepatch, Per Square Centimeter	Not subject to pre-service review. Check EIU	12/31/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4237	Cryo-Cord, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
Q4231	Oryo-Cord, Fer Square Certifficier	Not subject to pre-service review. Check EIU	12/31/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4238	Derm-Maxx, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2022	12/31/2999
Q 1200	Bom maza, i di oqualo bomamotor	Not subject to pre-service review. Check EIU	12/01/2000
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4239	Amnio-Maxx Or Amnio-Maxx Lite, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4240	Corecyte, For Topical Use Only, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4241	Polycyte, For Topical Use Only, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4242	Amniocyte Plus, Per 0.5 Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4245	Amniotext, Per Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4246	Coretext Or Protext, Per Cc	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4247	Amniotext Patch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4248	Dermacyte Amniotic Membrane Allograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4249	Amniply, For Topical Use Only, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 3/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4250	Amnioamp-Mp, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 3/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4251	Vim, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4252	Vendaje, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4050	Zouith Associatio Massockers and Don Consession Continued and	Coding Policy (CPCP).	40/04/0000
Q4253	Zenith Amniotic Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
Q4254	Novafix DI, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 3/1/2021	12/31/2999
Q4254	Novalix Di, Per Square Centimeter	Not subject to pre-service review. Check EIU	12/3 1/2999
		policy, which is one of our Clinical Payment and	
Q4255	Reguard, For Topical Use Only, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 3/1/2021	12/31/2999
Q4200	reguard, For Topical Ose Only, Per Square Certimeter	Not subject to pre-service review. Check EIU	12/3 1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4256	Mlg-Complete, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2022	12/31/2999
Q4230	iving-complete, Fer Square Centiffleter		12/3 1/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4257	Relese, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
)4258	Enverse, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4259	Celera Dual Layer Or Celera Dual Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4260	Signature Apatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4261	Tag, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4262	Dual Layer Impax Membrane, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4263	Surgraft TI, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4264	Cocoon Membrane, Per Square Centimeter	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4265	Neostim TI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4266	Neostim Membrane, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4267	Neostim DI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4268	Surgraft Ft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
(4269	Surgraft Xt, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4270	Complete SI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4271	Complete Ft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4272	Esano A, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4273	Esano Aaa, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4274	Esano Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4275	Esano Aca, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4276	Orion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4070	F: " + P 0 0 1: +	Coding Policy (CPCP).	10/04/0000
Q4278	Epieffect, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04070	Vandaia Aa Day Cawana Cantinaatan	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
Q4279	Vendaje Ac, Per Square Centimeter		12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
Q4280	Xcell Amnio Matrix, Per Square Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
Q4200	Aceil Allillo Matrix, Fel Square Cellullietel	Not subject to pre-service review. Check EIU	12/3/1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4281	Barrera SI Or Barrera DI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
Q7201	Danisia of Or Daniera Di, i et oquale Gentimetel	Not subject to pre-service review. Check EIU	12/3/1/2999
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4282	Cygnus Dual, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 12/1/2023	12/31/2999
Q-7202	Sygnus Buai, i or oquare ocnumeter	Not subject to pre-service review. Check EIU	12/01/2000
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
		County CFCF).	

Q4283	Biovance Tri-Layer Or Biovance 3L, Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	7/15/2024	12/31/2999
		Clinical Review to avoid post-service review.		
Q4283	Biovance Tri-Layer Or Biovance 3L, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4284	Dermabind SI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4285	Nudyn DI Or Nudyn DI Mesh, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
0.4000	Northern Cl Con Northern Class Born Conserve Constitution	Coding Policy (CPCP).	40/4/0000	40/04/0000
Q4286	Nudyn SI Or Nudyn Slw, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and Coding Policy (CPCP).		
Q4287	Dermabind DI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
Q4201	Dermabilia bi, Fei Squale Centimetei	Not subject to pre-service review. Check EIU	77172024	12/3/1/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4288	Dermabind Ch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	., .,,-	1-1-1-1-1-1
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4289	Revoshield + Amniotic Barrier, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4290	Membrane Wrap-Hydro, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
Q4291	Lawrelles VA Day Carrey Cambina share	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan.	7/4/0004	12/31/2999
Q4291	Lamellas Xt, Per Square Centimeter	Not subject to pre-service review. Check EIU	7/1/2024	12/31/2999
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4292	Lamellas, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
~ .EVE		Not subject to pre-service review. Check EIU	., 1/2024	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4293	Acesso DI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	,	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		

Q4294	Amnio Quad-Core, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
4295	Amnio Tri-Core Amniotic, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
4296	Rebound Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
4297	Emerge Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4298	Amnicore Pro, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
14299	Amnicore Pro+, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4300	Acesso TI, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4301	Activate Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4302	Complete Aca, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
4303	Complete Aa, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
4304	Grafix Plus, Per Square Centimeter	MP Criteria: Procedure/service reviewed against 1/1/202	4 12/31/2999
		Medical Policy Criteria. Submit for Recommended	
		Clinical Review to avoid post-service review.	
4305	American Amnion Ac Tri-Layer, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/202	4 12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4306	American Amnion Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4307	American Amnion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4308	Sanopellis, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4309	Via Matrix, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4310	Procenta, Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. 4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4311	Acesso, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4312	Acesso Ac, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4313	Dermabind Fm, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.10.1.1	5.5.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0	Coding Policy (CPCP).	10/04/0000
Q4314	Reeva Ft, Per Square Cenitmeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04045	De constitut Acceptation Manuel constitution Allegard for Dec Constitution of the	Coding Policy (CPCP).	40/04/0000
Q4315	Regenelink Amniotic Membrane Allograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4040	And the select Deep Conserve Constitution	Coding Policy (CPCP).	40/04/0000
Q4316	Amchoplast, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04047	Vita sueft Day Causes Continuates	Coding Policy (CPCP).	40/04/0000
Q4317	Vitograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4318	E-Graft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4319	Sanograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4320	Pellograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4321	Renograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4322	Caregraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4323	Alloply, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4324	Amniotx, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	
Q4325	Acapatch, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.1000		Coding Policy (CPCP).	10/01/0000
Q4326	Woundplus, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
0.4007	Donas de Dan Carrera Constitue des	Coding Policy (CPCP).	40/04/0000
Q4327	Duoamnion, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04000	Mant Day Course Continuator	Coding Policy (CPCP).	40/04/0000
Q4328	Most, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
04220	Cingley Per Cauero Centimeter	Coding Policy (CPCP).  EIU: Procedure/service not reimbursed by the Plan. 7/1/2024	12/21/2000
Q4329	Singlay, Per Square Centimeter		12/31/2999
		Not subject to pre-service review. Check EIU	
		policy, which is one of our Clinical Payment and	
		Coding Policy (CPCP).	

Q4330	Total, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4331	Axolotl Graft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4332	Axolotl Dualgraft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q4333	Ardeograft, Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
Q5106	Injection, Epoetin Alfa-Epbx, Biosimilar, (Retacrit) (For Non-Esrd Use), 1000 Units	MP Criteria: Procedure/service reviewed against	10/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5109	Injection, Infliximab-Qbtx, Biosimilar, (Ixifi), 10 Mg	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5124	Injection, Ranibizumab-Nuna, Biosimilar, (Byooviz), 0.1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5128	Injection, Ranibizumab-Eqrn (Cimerli), Biosimilar, 0.1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5131	Injection, Adalimumab-Aacf (Idacio), Biosimilar, 20 Mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5133	Injection, Tocilizumab-Bavi (Tofidence), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5134	Injection, Natalizumab-Sztn (Tyruko), Biosimilar, 1 Mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5138	Injection, Ustekinumab-Auub (Wezlana), Biosimilar, Intravenous, 1 Mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q9004	Department Of Veterans Affairs Whole Health Partner Services	Non Covered: Procedure/service not covered by	10/1/2021	12/31/2999
00000	Flaton demand E40 Picona etic Par Ct. L. D L. T. SARIII	the Plan. Not subject to pre-service review.	0/4/0000	40/04/0000
Q9982	Flutemetamol F18, Diagnostic, Per Study Dose, Up To 5 Millicuries	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
00000		Clinical Review to avoid post-service review.	0/4/0000	40/04/0655
Q9983	Florbetaben F18, Diagnostic, Per Study Dose, Up To 8.1 Millicuries	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S0013	Esketamine, Nasal Spray, 1 Mg	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
30122	Injection, Menotropins, 75 lu	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
30126	Injection, Follitropin Alfa, 75 lu	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S0128	Injection, Follitropin Beta, 75 lu	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S0155	Sterile Dilutant For Epoprostenol, 50Ml	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0157	Becaplermin Gel 0. 01%, 0. 5 Gm	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0194	Dialysis/Stress Vitamin Supplement, Oral100 Capsules	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2010-		the Plan. Not subject to pre-service review.	4/4/0005	10/01/0000
S0197	Prenatal Vitamins, 30-Day Supply	Non Covered: Procedure/service not covered by	4/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
S0207	Paramedic Intercept, Non-Hospital-Based Als Service (Non-Voluntary), Non-	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Transport	the Plan. Not subject to pre-service review.		
S0209	Wheelchair Van, Mileage, Per Mile	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0215	Non-Emergency Transportation; Mileage, Per Mile	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
2225		Clinical Review to avoid post-service review.	4/4/0005	10/01/0000
S0257	Counseling And Discussion Regarding Advance Directives Or End Of Life Care	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Planning And Decisions, With Patient And/Or Surrogate (List Separately In	the Plan. Not subject to pre-service review.		
20045	Addition To Code For Appropriate Evaluation And Management Service)	New Occurred Dress days to see the section of the s	4/4/4050	40/04/0000
S0315	Disease Management Program; Initial Assessment And Initiation Of The Program	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
S0316	Discount Management December Fallow Har/December 4	the Plan. Not subject to pre-service review.	1/1/1950	40/04/0000
50316	Disease Management Program; Follow-Up/Reassessment	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
S0317	Discourant Description Description	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
50317	Disease Management Program; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
S0320	Talambana Calla Diy A. Danistanad Niyesa Ta A. Disasaa Manananant Dramana	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
50320	Telephone Calls By A Registered Nurse To A Disease Management Program	•	1/1/1950	12/31/2999
20000	Member For Monitoring Purposes; Per Month	the Plan. Not subject to pre-service review.	0/4/0007	40/04/0000
S0390	Routine Foot Care; Removal And/Or Trimming Of Corns, Calluses And/Or Nails	MP Criteria: Procedure/service reviewed against	9/1/2007	12/31/2999
	And Preventive Maintenance In Specific Medical Conditions (E. G. Diabetes), Per	Medical Policy Criteria. Submit for Recommended		
20540	Visit	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
30510	Non-Prescription Lens (Safety, Athletic, Or Sunglass), Per Lens	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
S0514	Colon Contact Long Don Long	the Plan. Not subject to pre-service review.	1/1/1950	40/04/0000
50514	Color Contact Lens, Per Lens	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
20540	Cafabi Fireniana Franca	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
S0516	Safety Eyeglass Frames	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
20540	0	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
50518	Sunglasses Frames	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

S0596	Phakic Intraocular Lens For Correction Of Refractive Error	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	4/1/2012	12/31/2999
		•		
20000	Dhariad Farm For Calle and New On Fatablish ad Dation (1) int Commentation	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
S0622	Physical Exam For College, New Or Established Patient (List Separately In	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Addition To Appropriate Evaluation And Management Code)	the Plan. Not subject to pre-service review.	4/45/0000	10/04/0000
S0800	Laser In Situ Keratomileusis (Lasik)	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0810	Photorefractive Keratectomy (Prk)	Non Covered: Procedure/service not covered by	1/1/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
S0812	Phototherapeutic Keratectomy (Ptk)	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S1030	Continuous Noninvasive Glucose Monitoring Device, Purchase (For Physician	MP Criteria: Procedure/service reviewed against	4/15/2009	12/31/2999
	Interpretation Of Data, Use Cpt Code)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S1031	Continuous Noninvasive Glucose Monitoring Device, Rental, Including Sensor,	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
	Sensor Replacement, And Download To Monitor (For Physician Interpretation Of	Medical Policy Criteria. Submit for Recommended		
	Data, Use Cpt Code)	Clinical Review to avoid post-service review.		
S1034	Artificial Pancreas Device System (Eg, Low Glucose Suspend [Lgs] Feature)	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
	Including Continuous Glucose Monitor, Blood Glucose Device, Insulin Pump And	Medical Policy Criteria. Submit for Recommended		
	Computer Algorithm That Communicates With All Of The Devices	Clinical Review to avoid post-service review.		
S1035	Sensor; Invasive (Eg, Subcutaneous), Disposable, For Use With Artificial	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
	Pancreas Device System, 1 Unit = 1 Day Supply	Medical Policy Criteria. Submit for Recommended		
	, , , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
S1036	Transmitter; External, For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S1037	Receiver (Monitor); External, For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S1040	Cranial Remolding Orthosis, Pediatric, Rigid, With Soft Interface Material, Custom	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	Fabricated, Includes Fitting And Adjustment(S)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S1091	Stent, Non-Coronary, Temporary, With Delivery System (Propel)	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		, . ,
		Clinical Review to avoid post-service review.		
S2080	Laser-Assisted Uvulopalatoplasty (Laup)	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended	0, 1, 2020	12/01/2000
		Clinical Review to avoid post-service review.		
S2083	Adjustment Of Gastric Band Diameter Via Subcutaneous Port By Injection Or	MP Criteria: Procedure/service reviewed against	4/1/2004	12/31/2999
	Aspiration Of Saline	Medical Policy Criteria. Submit for Recommended	1,1,2004	12/01/2000
	/ topication of dallife	Clinical Review to avoid post-service review.		
S2095	Transcatheter Occlusion Or Embolization For Tumor Destruction, Percutaneous,	MP Criteria: Procedure/service reviewed against	2/1/2008	12/31/2999
02000	Any Method, Using Yttrium-90 Microspheres	Medical Policy Criteria. Submit for Recommended	2/ 1/2000	12/01/2000
	Any Method, Oshiy i thum-so Microspheres	Clinical Review to avoid post-service review.		
S2102	Islet Cell Tissue Transplant From Pancreas; Allogeneic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
OZ 10Z	nsiet Geit rissue franspiant From Fancteas, Allogeneic		3/ 1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S2103	Adrenal Tissue Transplant To Brain	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
32103	Adrenal rissue transplant to brain	Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
		•		
S2107	Adoptive Immunotherapy I. E. Development Of Specific Anti-Tumor Reactivity (E.	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
2107	G. Tumor-Infiltrating Lymphocyte Therapy) Per Course Of Treatment	Medical Policy Criteria. Submit for Recommended	9/1/2020	12/31/2999
	G. Tumor-militating Lymphocyte Therapy) Per Course Of Treatment			
20440	Authorosomy (Anno Cymeigal Fan Hawyseting Of Contilons (Chandus outs Calla)	Clinical Review to avoid post-service review.	1/1/1950	40/04/0000
52112	Arthroscopy, Knee, Surgical For Harvesting Of Cartilage (Chondrocyte Cells)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0117		Clinical Review to avoid post-service review.	40/4/0000	10/01/0000
2117	Arthroereisis, Subtalar	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2140	Cord Blood Harvesting For Transplantation, Allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2142	Cord Blood-Derived Stem-Cell Transplantation, Allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2150	Bone Marrow Or Blood-Derived Stem Cells (Peripheral Or Umbilical), Allogeneic	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Or Autologous, Harvesting, Transplantation, And Related Complications; Including:			
	Pheresis And Cell Preparation/Storage; Marrow Ablative Therapy; Drugs, Supplies,	Clinical Review to avoid post-service review.		
	Hospitalization With Outpatient Follow-Up; Medical/Surgical, Diagnostic,	·		
	Emergency, And Rehabilitative Services; And The Number Of Days Of Pre-And			
	Post-Transplant Care In The Global Definition			
2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2230	Implantation Of Magnetic Component Of Semi-Implantable Hearing Device On	MP Criteria: Procedure/service reviewed against	10/1/2003	12/31/2999
	Ossicles In Middle Ear	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2235	Implantation Of Auditory Brain Stem Implant	MP Criteria: Procedure/service reviewed against	10/1/2003	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2300	Arthroscopy, Shoulder, Surgical; With Thermally-Induced Capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	,,,,,	Not subject to pre-service review. Check EIU	,	
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
2348	Decompression Procedure, Percutaneous, Of Nucleus Pulposus Of Intervertebral	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
20.0	Disc, Using Radiofrequency Energy, Single Or Multiple Levels, Lumbar	Medical Policy Criteria. Submit for Recommended	0, 1,2020	12/01/2000
	Bloc, Colling Radion Equation of Energy, Christic Of Waltapie Edvoid, Earnbai	Clinical Review to avoid post-service review.		
2400	Repair, Congenital Diaphragmatic Hernia In The Fetus Using Temporary Tracheal	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
2.00	Occlusion, Procedure Performed In Utero	Medical Policy Criteria. Submit for Recommended	5, 1,2020	12/01/2000
	Sociation, i roccadio i chomica in otoro	Clinical Review to avoid post-service review.		
2401	Repair, Urinary Tract Obstruction In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
, LTU I	Tropair, Officially Tract Obstituction in The Fetus, Flocedule Fetionfied III Otelo	ĕ	11/1/2012	12/01/2000
		Medical Policy Criteria. Submit for Recommended		
2402	Repair, Congenital Cystic Adenomatoid Malformation In The Fetus, Procedure	Clinical Review to avoid post-service review.  MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
82402			11/1/2012	12/3/1/2999
	Performed In Utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

S2403	Repair, Extralobar Pulmonary Sequestration In The Fetus, Procedure Performed In		11/1/2012	12/31/2999
	Utero	Medical Policy Criteria. Submit for Recommended		
20404	Denois Markey with a college The Catal Decoder Defended in the co	Clinical Review to avoid post-service review.	0/04/0040	40/04/0000
2404	Repair, Myelomeningocele In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.405	D : 0(0 17 / 17 F / D 1 D ( 11 III	Clinical Review to avoid post-service review.	4.4.14.100.40	40/04/0000
32405	Repair Of Sacrococcygeal Teratoma In The Fetus, Procedure Performed In Utero	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2409	Repair, Congenital Malformation Of Fetus, Procedure Performed In Utero, Not	MP Criteria: Procedure/service reviewed against	2/15/2007	12/31/2999
	Otherwise Classified	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2411	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin Transfusion Syndrome	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33650	Saliva Test, Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
33652	Saliva Test, Hormone Level; To Assess Preterm Labor Risk	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
3655	Antisperm Antibodies Test (Immunobead)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S3722	Dose Optimization By Area Under The Curve (Auc) Analysis, For Infusional 5-	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Fluorouracil	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S3900	Surface Electromyography (Emg)	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
	7 3 1 7 ( 3)	Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S4005	Interim Labor Facility Global (Labor Occurring But Not Resulting In Delivery)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	., ., .,	12/01/2000
S4011	In Vitro Fertilization; Including But Not Limited To Identification And Incubation Of	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
5-1011	Mature Oocytes, Fertilization With Sperm, Incubation Of Embryo(S), And	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
	Subsequent Visualization For Determination Of Development	The Flan. Not subject to pre-service review.		
S4013	Complete Cycle, Gamete Intrafallopian Transfer (Gift), Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
04010	Complete Cycle, Carlete Intraralloplan Transfer (Cliry, Case Nate	the Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
S4014	Complete Cycle, Zygote Intrafallopian Transfer (Zift), Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
940 14	Complete Cycle, Zygote intrafalloplan Transfer (Zitt), Case Nate	· · · · · · · · · · · · · · · · · · ·	1/1/1930	12/3/1/2999
34015	Complete In Vitro Fertilization Cycle, Not Otherwise Specified, Case Rate	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
94015	Complete in vitro Fertilization Cycle, Not Otherwise Specified, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
14040	Francis In Vitus Fortilization Cools Cons. Date	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
84016	Frozen In Vitro Fertilization Cycle, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	4444055	10/01/6
34017	Incomplete Cycle, Treatment Cancelled Prior To Stimulation, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
34018	Frozen Embryo Transfer Procedure Cancelled Before Transfer, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

S4020	In Vitro Fertilization Procedure Cancelled Before Aspiration, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
24004	In Vitan Fortille tion Borne day Councilled After Assistation Councilled		4/4/4050	10/01/0000
64021	In Vitro Fertilization Procedure Cancelled After Aspiration, Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4022	Assisted Oocyte Fertilization, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
74022	Assisted Godyte Fertilization, Gase Nate	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
64023	Donor Egg Cycle, Incomplete, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
04020	Bollot Egg Cycle, illcomplete, Case Nate	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
34025	Donor Services For In Vitro Fertilization (Sperm Or Embryo), Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	251131 351 1130 1 31 111 2 1 31 111 2 1 31 111 31 31 11 11 31 31 11 31 11 31 11 31 11 31 11 31 11 31 11 31 11 31 11 31 11 31 3	the Plan. Not subject to pre-service review.	., .,	, 0 ., _ 0 0 0
S4026	Procurement Of Donor Sperm From Sperm Bank	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4027	Storage Of Previously Frozen Embryos	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4028	Microsurgical Epididymal Sperm Aspiration (Mesa)	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4030	Sperm Procurement And Cryopreservation Services; Initial Visit	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4031	Sperm Procurement And Cryopreservation Services; Subsequent Visit	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4035	Stimulated Intrauterine Insemination (Iui), Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4037	Cryopreserved Embryo Transfer, Case Rate	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S4040	Monitoring And Storage Of Cryopreserved Embryos, Per 30 Days	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
54042	Management Of Ovulation Induction (Interpretation Of Diagnostic Tests And	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Studies, Non-Face-To-Face Medical Management Of The Patient), Per Cycle	the Plan. Not subject to pre-service review.		
S4988	Penile Contracture Device, Manual, Greater Than 3 Lbs Traction Force	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S4990	Nicotine Patches, Legend	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
54991	Nicotine Patches, Non-Legend	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
34995	Smoking Cessation Gum	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
35100	Day Care Services, Adult; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
35101	Day Care Services, Adult; Per Half Day	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
55102	Day Care Services, Adult; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
55105	Day Care Services, Center-Based; Services Not Included In Program Fee, Per	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Diem	the Plan. Not subject to pre-service review.		
\$5108	Home Care Training To Home Care Client, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5109	Home Care Training To Home Care Client, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

S5110	Home Care Training, Family; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5111	Home Care Training, Family; Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
55111	Tionie Care Halling, Failing, Fel Session	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
S5115	Home Care Training, Non-Family; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
55115	Tionie Care Hailing, Non-Family, Fer 15 Williales	the Plan. Not subject to pre-service review.	1/1/1930	12/3/1/2999
S5116	Home Care Training, Non-Family; Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
33110	Tionie Gale Halling, North annity, i et Gession	the Plan. Not subject to pre-service review.	1/1/1950	12/3/1/2999
35120	Chore Services: Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
30120	Office dervices, i er to williates	the Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
S5121	Chore Services; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	S.10.0 S.3.11033, 1 S.1 S.10111	the Plan. Not subject to pre-service review.	., .,	12/01/2000
S5125	Attendant Care Services; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
-0.20	, monaum out of the services of the minutes	the Plan. Not subject to pre-service review.	., .,	12/01/2000
S5126	Attendant Care Services; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1.2.1.2.1.2
S5130	Homemaker Service, Nos; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1.2.1.2.1.2
S5131	Homemaker Service, Nos; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5135	Companion Care, Adult (E. G. ladl/Adl); Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5136	Companion Care, Adult (E. G. ladl/Adl); Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5140	Foster Care, Adult; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5141	Foster Care, Adult; Per Month	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5145	Foster Care, Therapeutic, Child; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5146	Foster Care, Therapeutic, Child; Per Month	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5150	Unskilled Respite Care, Not Hospice; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5151	Unskilled Respite Care, Not Hospice; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5160	Emergency Response System; Installation And Testing	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5161	Emergency Response System; Service Fee, Per Month (Excludes Installation And	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Testing)	the Plan. Not subject to pre-service review.		
S5162	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5165	Home Modifications; Per Service	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5170	Home Delivered Meals, Including Preparation; Per Meal	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5175	Laundry Service, External, Professional; Per Order	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S5185	Medication Reminder Service, Non-Face-To-Face; Per Month	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

S5199	Personal Care Item, Nos, Each	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8040	Topographic Brain Mapping	MP Criteria: Procedure/service reviewed against	12/15/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8080	Scintimammography (Radioimmunoscintigraphy Of The Breast), Unilateral,	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Including Supply Of Radiopharmaceutical	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8130	Interferential Current Stimulator, 2 Channel	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S8131	Interferential Current Stimulator, 4 Channel	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S8185	Flutter Device	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8270	Enuresis Alarm, Using Auditory Buzzer And/Or Vibration Device	Non Covered: Procedure/service not covered by	7/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
S8930	Electrical Stimulation Of Auricular Acupuncture Points; Each 15 Minutes Of	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Personal One-On-One Contact With The Patient	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S8940	Equestrian/Hippotherapy, Per Session	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU		
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S8948	Application Of A Modality (Requiring Constant Provider Attendance) To One Or	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	More Areas; Low-Level Laser; Each 15 Minutes	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
S8990	Physical Or Manipulative Therapy Performed For Maintenance Rather Than	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	Restoration	Medical Policy Criteria. Submit for Recommended	07.72020	12/01/2000
	Trocks and the second s	Clinical Review to avoid post-service review.		
S9001	Home Uterine Monitor With Or Without Associated Nursing Services	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
00001	Trome desime memory with or without recondition realising convices	Not subject to pre-service review. Check EIU	12, 10,2011	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S9002	Intra-Vaginal Motion Sensor System, Provides Biofeedback For Pelvic Floor	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	Muscle Rehabilitation Device	Medical Policy Criteria. Submit for Recommended	", ", ", ", ", ", ", ", ", ", ", ", ", "	12/01/2000
	IVIUSOIC I (CHADIIII CHIO) DEVICE	Clinical Review to avoid post-service review.		
S9055	Procuren Or Other Growth Factor Preparation To Promote Wound Healing	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
09000	I rocaren or other Growth ractor Freparation to Fromote Would Healing		3/ 1/2020	12/3/1/2000
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	1	

S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
20000		Not subject to pre-service review. Check EIU	12/1/2020	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S9090	Vertebral Axial Decompression, Per Session	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	12/31/2999
00000	Vertebrar / Wildi Bedoniproceion, For Geodelin	Not subject to pre-service review. Check EIU	12/10/2014	12/01/2000
		policy, which is one of our Clinical Payment and		
		Coding Policy (CPCP).		
S9117	Back School, Per Visit	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended	07.72020	1.270172000
		Clinical Review to avoid post-service review.		
S9125	Respite Care, In The Home, Per Diem	Non Covered: Procedure/service not covered by	3/1/2008	12/31/2999
55.25	respire outs, in the name, i si Bisin	the Plan. Not subject to pre-service review.	07.172000	12/01/2000
S9128	Speech Therapy, In The Home, Per Diem	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
00.20	operation and the training it of 2 to the	Medical Policy Criteria. Submit for Recommended	.,,_	12/01/2000
		Clinical Review to avoid post-service review.		
S9129	Occupational Therapy, In The Home, Per Diem	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1-1-1-1
		Clinical Review to avoid post-service review.		
S9131	Physical Therapy; In The Home, Per Diem	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9145	Insulin Pump Initiation, Instruction In Initial Use Of Pump (Pump Not Included)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9335	Home Therapy, Hemodialysis; Administrative Services, Professional Pharmacy	MP Criteria: Procedure/service reviewed against	4/15/2008	12/31/2999
	· · · · · · · · · · · · · · · · · ·	Medical Policy Criteria. Submit for Recommended		
	And Nursing Services Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
S9340	Home Therapy; Enteral Nutrition; Administrative Services, Professional Pharmacy	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Services, Care Coordination, And All Necessary Supplies And Equipment (Enteral			
	Formula And Nursing Visits Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
S9341	Home Therapy; Enteral Nutrition Via Gravity; Administrative Services, Professional	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Medical Policy Criteria. Submit for Recommended		
	Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
		·		
S9342	Home Therapy; Enteral Nutrition Via Pump; Administrative Services, Professional	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Medical Policy Criteria. Submit for Recommended		
	Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
S9343	Home Therapy; Enteral Nutrition Via Bolus; Administrative Services, Professional	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Medical Policy Criteria. Submit for Recommended		
	Equipment (Enteral Formula And Nursing Visits Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
S9355		MP Criteria: Procedure/service reviewed against	10/15/2007	12/31/2999
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Medical Policy Criteria. Submit for Recommended		
	Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	Clinical Review to avoid post-service review.		
S9364		MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Professional Pharmacy Services, Care Coordination, And All Necessary Supplies	Medical Policy Criteria. Submit for Recommended		
	And Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid	Clinical Review to avoid post-service review.		
	Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded	· ·		
	Separately), Per Diem (Do Not Use With Home Infusion Codes S9365-S9368			
	Using Daily Volume Scales)	1	Ī	

S9366	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than One Liter But	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	No More Than Two Liters Per Day, Administrative Services, Professional	Medical Policy Criteria. Submit for Recommended		
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Clinical Review to avoid post-service review.		
	Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid			
	Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded			
	Separately), Per Diem		0/4.4/0000	10/01/0000
S9367	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than Two Liters	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	But No More Than Three Liters Per Day, Administrative Services, Professional	Medical Policy Criteria. Submit for Recommended		
	Pharmacy Services, Care Coordination, And All Necessary Supplies And	Clinical Review to avoid post-service review.		
	Equipment Including Standard Tpn Formula (Lipids, Specialty Amino Acid			
	Formulas, Drugs Other Than In Standard Formula And Nursing Visits Coded			
	Separately), Per Diem			
S9368	Home Infusion Therapy, Total Parenteral Nutrition (Tpn); More Than Three Liters	MP Criteria: Procedure/service reviewed against	9/14/2009	12/31/2999
	Per Day, Administrative Services, Professional Pharmacy Services, Care	Medical Policy Criteria. Submit for Recommended		
	Coordination, And All Necessary Supplies And Equipment Including Standard Tpn	Clinical Review to avoid post-service review.		
	Formula (Lipids, Specialty Amino Acid Formulas, Drugs Other Than In Standard			
	Formula And Nursing Visits Coded Separately), Per Diem			
S9381	Delivery Or Service To High Risk Areas Requiring Escort Or Extra Protection, Per	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Visit	the Plan. Not subject to pre-service review.		
S9401	Anticoagulation Clinic, Inclusive Of All Services Except Laboratory Tests, Per	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Session	the Plan. Not subject to pre-service review.		
S9430	Pharmacy Compounding And Dispensing Services	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9432	Medical Foods For Non-Inborn Errors Of Metabolism	Non Covered: Procedure/service not covered by	10/1/2021	12/31/2999
		the Plan. Not subject to pre-service review.		
S9434	Modified Solid Food Supplements For Inborn Errors Of Metabolism	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S9435	Medical Foods For Inborn Errors Of Metabolism	MP Criteria: Procedure/service reviewed against	7/27/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S9436	Childbirth Preparation/Lamaze Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S9437	Childbirth Refresher Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S9438	Cesarean Birth Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S9439	Vbac (Vaginal Birth After Cesarean) Classes, Non-Physician Provider, Per	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Session	the Plan. Not subject to pre-service review.		
S9441	Asthma Education, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
S9442	Birthing Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		
S9444	Parenting Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	1	
S9445	Patient Education, Not Otherwise Classified, Non-Physician Provider, Individual,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Per Session	the Plan. Not subject to pre-service review.	., ,, ,,,,,,	12/01/2000
39446	Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Session	the Plan. Not subject to pre-service review.	., ., .,	12/01/2000

S9447	Infant Safety (Including Cpr) Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9449	Weight Management Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9451	Exercise Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9454	Stress Management Classes, Non-Physician Provider, Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9472	Cardiac Rehabilitation Program, Non-Physician Provider, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S9473	Pulmonary Rehabilitation Program, Non-Physician Provider, Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2008	12/31/2999
S9482	Family Stabilization Services, Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
S9537	Csf, Gm-Csf); Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately). Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
S9558	Home Injectable Therapy; Growth Hormone, Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2015	12/31/2999
S9560	Home Injectable Therapy; Hormonal Therapy (E. G.; Leuprolide, Goserelin), Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
S9562	Home Injectable Therapy, Palivizumab Or Other Monoclonal Antibody For Rsv, Including Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately), Per Diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9810	Home Therapy; Professional Pharmacy Services For Provision Of Infusion, Specialty Drug Administration, And/Or Disease State Management, Not Otherwise Classified, Per Hour (Do Not Use This Code With Any Per Diem Code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
S9900	Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing. Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9960	Ambulance Service, Conventional Air Services, Nonemergency Transport, One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9961	Ambulance Service, Conventional Air Service, Nonemergency Transport, One Way (Rotary Wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9970	Health Club Membership, Annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9976	Lodging, Per Diem, Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9977	Meals, Per Diem, Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

S9981	Medical Records Copying Fee, Administrative	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9982	Medical Records Copying Fee, Per Page	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9986	Not Medically Necessary Service (Patient Is Aware That Service Not Medically	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Necessary)	the Plan. Not subject to pre-service review.		
9988	Services Provided As Part Of A Phase I Clinical Trial	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9989	Services Provided Outside Of The United States Of America (List In Addition To	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Code(S) For Services(S))	the Plan. Not subject to pre-service review.		
9990	Services Provided As Part Of A Phase li Clinical Trial	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
39991	Services Provided As Part Of A Phase Iii Clinical Trial	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
9992	Transportation Costs To And From Trial Location And Local Transportation Costs	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	(E. G. , Fares For Taxicab Or Bus) For Clinical Trial Participant And One	the Plan. Not subject to pre-service review.		1.2, 5 1, 2 5 5
	Caregiver/Companion	The consider to pro-dorvico review.		
9994	Lodging Costs (E. G. , Hotel Charges) For Clinical Trial Participant And One	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
.0004	Caregiver/Companion	the Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
9996	Meals For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
19990	Interior of Chillical That Fatticipant And One Caregiver/Companion	the Plan. Not subject to pre-service review.	1/1/1930	12/3 1/2999
9999	Sales Tax	Non Covered: Procedure/service not covered by	6/1/2014	12/31/2999
9999	Sales Tax		0/1/2014	12/31/2999
4005	Descrite Cons Considers Ha To 45 Minutes	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
1005	Respite Care Services, Up To 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
1000		the Plan. Not subject to pre-service review.	4/4/4050	10/01/0000
1006	Alcohol And/Or Substance Abuse Services, Family/Couple Counseling	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
1009	Child Sitting Services For Children Of The Individual Receiving Alcohol And/Or	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Substance Abuse Services	the Plan. Not subject to pre-service review.		
1010	,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Meals Not Included In The Program)	the Plan. Not subject to pre-service review.		
1012	Alcohol And/Or Substance Abuse Services, Skills Development	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
1013	Sign Language Or Oral Interpretive Services, Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
1014	Telehealth Transmission, Per Minute, Professional Services Bill Separately	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
1018	School-Based Individualized Education Program (lep) Services, Bundled	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
1019	Personal Care Services, Per 15 Minutes, Not For An Inpatient Or Resident Of A	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Hospital, Nursing Facility, Icf/Mr Or Imd, Part Of The Individualized Plan Of	the Plan. Not subject to pre-service review.		
	Treatment (Code May Not Be Used To Identify Services Provided By Home Health			
	Aide Or Certified Nurse Assistant)			
T1029	Comprehensive Environmental Lead Investigation, Not Including Laboratory	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Analysis, Per Dwelling	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
1032	Services Performed By A Doula Birth Worker, Per 15 Minutes	Non Covered: Procedure/service not covered by	10/1/2022	12/31/2999
1032	Ocivides Felidiffied by A Doula billi Worker, Fer 13 Williales	•	10/1/2022	12/31/2999
1033	Comisso Derformed Dv A Devile Dirth Warter Day Diago	the Plan. Not subject to pre-service review.	10/1/2022	12/31/2999
1033	Services Performed By A Doula Birth Worker, Per Diem	Non Covered: Procedure/service not covered by	10/1/2022	12/31/2999
		the Plan. Not subject to pre-service review.		

T2001	Non-Emergency Transportation; Patient Attendant/Escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
T2002	Non-Emergency Transportation; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2002	INOT-Emergency Transportation, Fer Diem	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
2003	Non-Emergency Transportation; Encounter/Trip	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2003	INOT-Emergency Transportation, Encounter/Trip	•	1/1/1950	12/31/2999
T2004	Non-Engage and Transport Communical Comics Modification	the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
12004	Non-Emergency Transport; Commercial Carrier, Multi-Pass	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
Γ2005	Non-Emergency Transportation; Stretcher Van	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2005	INOT-Emergency Transportation, Stretcher van		1/1/1950	12/31/2999
T2007	Transportation Waiting Time, Air Ambulance And Non-Emergency Vehicle, One-	the Plan. Not subject to pre-service review.  Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
12007	· · · · · · · · · · · · · · · · · · ·	•	1/1/1950	12/31/2999
50040	Half (1/2) Hour Increments Habilitation, Educational; Waiver, Per Diem	the Plan. Not subject to pre-service review.	1/1/1950	10/01/0000
Γ2012	Habilitation, Educational; Walver, Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
50040	Habitation Educational Matters Beatless	the Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
Γ2013	Habilitation, Educational, Waiver; Per Hour	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2014	Habilitation, Prevocational, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2015	Habilitation, Prevocational, Waiver; Per Hour	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2016	Habilitation, Residential, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2017	Habilitation, Residential, Waiver; 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2018	Habilitation, Supported Employment, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2019	Habilitation, Supported Employment, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2020	Day Habilitation, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2021	Day Habilitation, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2026	Specialized Childcare, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2027	Specialized Childcare, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Γ2028	Specialized Supply, Not Otherwise Specified, Waiver	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
Г2029	Specialized Medical Equipment, Not Otherwise Specified, Waiver	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		1.2.0.11.200
T2034	Crisis Intervention, Waiver; Per Diem	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.	., .,	12/01/2000
2035	Utility Services To Support Medical Equipment And Assistive Technology/Devices,	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2000	Waiver	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
2036	Therapeutic Camping, Overnight, Waiver; Each Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2000	Therapeutic Camping, Overnight, Walver, Each Cession	the Plan. Not subject to pre-service review.	1/1/1000	12/01/2000
2037	Therapeutic Camping, Day, Waiver; Each Session	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
2031	Therapeutic Gamping, Day, Walver, Each Session	•	1/1/1950	12/31/2999
2038	Community Transition Waiver Day Comites	the Plan. Not subject to pre-service review.	1/1/1050	10/04/0000
2038	Community Transition, Waiver; Per Service	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		

Γ2039	Vehicle Modifications, Waiver; Per Service	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2040	Financial Management, Self-Directed, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2041	Supports Brokerage, Self-Directed, Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T2049	Non-Emergency Transportation; Stretcher Van, Mileage; Per Mile	Non Covered: Procedure/service not covered by	7/1/2004	12/31/2999
		the Plan. Not subject to pre-service review.		
T2050	Financial Management, Self-Directed, Waiver; Per Diem	Non Covered: Procedure/service not covered by	4/1/2022	12/31/2999
		the Plan. Not subject to pre-service review.		
T2051	Supports Brokerage, Self-Directed, Waiver; Per Diem	Non Covered: Procedure/service not covered by	4/1/2022	12/31/2999
		the Plan. Not subject to pre-service review.		
T2101	Human Breast Milk Processing, Storage And Distribution Only	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
T4521	Adult Sized Disposable Incontinence Product, Brief/Diaper, Small, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
4522	Adult Sized Disposable Incontinence Product, Brief/Diaper, Medium, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	the Plan. Not subject to pre-service review.		
T4523	Adult Sized Disposable Incontinence Product, Brief/Diaper, Large, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.	,	
T4524	Adult Sized Disposable Incontinence Product, Brief/Diaper, Extra Large, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Tradit 0/200 Biopodable modification in Todast, Birot/Biaper, Extra Earge, East	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
4525	Adult Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
14020	Small Size, Each	the Plan. Not subject to pre-service review.	1/1/2003	12/3 1/2999
4506	Adult Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
T4526			1/1/2005	12/31/2999
	Medium Size, Each	the Plan. Not subject to pre-service review.	1/1/2005	40/04/0000
4527	Adult Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Large Size, Each	the Plan. Not subject to pre-service review.	444000	10/01/0000
T4528	Adult Sized Disposable Incontinence Product, Protective Underwear/Pull-On, Extra	•	1/1/2005	12/31/2999
	Large Size, Each	the Plan. Not subject to pre-service review.		
T4529	Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Small/Medium	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Size, Each	the Plan. Not subject to pre-service review.		
T4530	Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Large Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
4531	Pediatric Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Small/Medium Size, Each	the Plan. Not subject to pre-service review.		
4532	Pediatric Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Large Size, Each	the Plan. Not subject to pre-service review.		
4533	Youth Sized Disposable Incontinence Product, Brief/Diaper, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
4534	Youth Sized Disposable Incontinence Product, Protective Underwear/Pull-On,	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	Each	the Plan. Not subject to pre-service review.		
4535	Disposable Liner/Shield/Guard/Pad/Undergarment, For Incontinence, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
17000	2.5253450 Enterior additional additional and an animal additional and animal additional and animal additional additional animal additional addi	the Plan. Not subject to pre-service review.	17 172000	12/01/2000
T4536	Incontinence Product, Protective Underwear/Pull-On, Reusable, Any Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
	incontinuo i roduot, i rotootivo orideriveai/i dii-Ori, ricusable, Arry olze, Lacif	the Plan. Not subject to pre-service review.	1/ 1/2003	12/01/2000
T4537	Incontinence Product, Protective Underpad, Reusable, Bed Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
4001	International Floudet, Floteetive Uniderpad, Reusable, Ded Size, Each	•	1/1/2005	12/31/2999
T.1500	Diaman Camina Daurahla Diaman Fasti Diaman	the Plan. Not subject to pre-service review.	4/4/0005	40/04/0000
4538	Diaper Service, Reusable Diaper, Each Diaper	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		

T4539	Incontinence Product, Diaper/Brief, Reusable, Any Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
T4540	Incontinence Product, Protective Underpad, Reusable, Chair Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
T4541	Incontinence Product, Disposable Underpad, Large, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
T4542	Incontinence Product, Disposable Underpad, Small Size, Each	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
T4543	Adult Sized Disposable Incontinence Product, Protective Brief/Diaper, Above Extra	Non Covered: Procedure/service not covered by	1/1/2007	12/31/2999
	Large, Each	the Plan. Not subject to pre-service review.		
T5001	Positioning Seat For Persons With Special Orthopedic Needs	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
V2627	Scleral Cover Shell	MP Criteria: Procedure/service reviewed against	6/5/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
V2702	Deluxe Lens Feature	Non Covered: Procedure/service not covered by	1/1/2005	12/31/2999
		the Plan. Not subject to pre-service review.		
V2745	Addition To Lens; Tint, Any Color, Solid, Gradient Or Equal, Excludes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Photochromatic, Any Lens Material, Per Lens	the Plan. Not subject to pre-service review.		
V2756	Eye Glass Case	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
/2761	Mirror Coating, Any Type, Solid, Gradient Or Equal, Any Lens Material, Per Lens	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
V2762	Polarization, Any Lens Material, Per Lens	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
		the Plan. Not subject to pre-service review.		
V2782	Lens, Index 1. 54 To 1. 65 Plastic Or 1. 60 To 1. 79 Glass, Excludes	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Polycarbonate, Per Lens	the Plan. Not subject to pre-service review.		
V2783	Lens, Index Greater Than Or Equal To 1. 66 Plastic Or Greater Than Or Equal To	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	1. 80 Glass, Excludes Polycarbonate, Per Lens	the Plan. Not subject to pre-service review.		
V2787	Astigmatism Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
/2788	Presbyopia Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
/2790	Amniotic Membrane For Surgical Reconstruction, Per Procedure	MP Criteria: Procedure/service reviewed against	7/1/2020	12/31/2999
	,, ,	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
/2797	Vision Supply, Accessory And/Or Service Component Of Another Hcpcs Vision	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Code	the Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
/5095	Semi-Implantable Middle Ear Hearing Prosthesis	MP Criteria: Procedure/service reviewed against	1/1/2003	12/31/2999
	Com implantable middle Ear rioding i roomoole	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
		Clinical Review to avoid post-service review.		
V5269	Assistive Listening Device, Alerting, Any Type	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	the Plan. Not subject to pre-service review.	1/ 1/ 1000	12/01/2000
V5270	Assistive Listening Device, Television Amplifier, Any Type	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
	Assistive Listerling Device, Television Amplilier, Amy Type	the Plan. Not subject to pre-service review.	1/1/1930	12/31/2333
V5271	Assistive Listening Device, Television Caption Decoder	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
V 321 1	Assistive Listerling Device, Television Capiton Decoder	•	1/1/1930	12/3/1/2999
		the Plan. Not subject to pre-service review.		

V52	72	Assistive Listening Device, Tdd	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
			the Plan. Not subject to pre-service review.		
V52	.73	Assistive Listening Device, For Use With Cochlear Implant	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
			the Plan. Not subject to pre-service review.		
V52	274	Assistive Listening Device, Not Otherwise Specified	Non Covered: Procedure/service not covered by	1/1/1950	12/31/2999
			the Plan. Not subject to pre-service review.		

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Please note that checking eligibility and benefits and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract.

Member contracts differ in their benefits. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of Oklahoma. For other services/members, BCBSOK has contracted with Carelon Medical Benefits Management for utilization management and related services.

Services performed without prior authorization, if required, will be denied for payment and providers may not seek reimbursement from BCBSOK members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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