

2025 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List Effective 1/1/2025 (Updated April 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 Groups	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.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
	Medical Policy Coverage statement indicates procedure/service is experimental, investigational, and/or unproven in all situations.
	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	Ending Date
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	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)	(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)	(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	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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 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
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
0101T	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
0102T	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)	for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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)	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).	5/15/2025	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. 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
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	,	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
0109Т	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).	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0110T	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).		12/31/2999
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation	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
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)	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
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, 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).	12/1/2020	12/31/2999
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s]	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	replacement), including facetectomy, laminectomy,	by the Plan. Not subject to pre-service		
	foraminotomy, and vertebral column fixation, injection of bone	review. Check EIU policy, which is one of		
	cement, when performed, including fluoroscopy, single level,	our Clinical Payment and Coding Policy		
	lumbar spine	(CPCP).		
0207T	Evacuation of meibomian glands, automated, using heat and	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	intermittent pressure, unilateral	by the Plan. Not subject to pre-service		
		review. Check EIU 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	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0209T	Pure tone audiometry (threshold), automated; air and bone	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0210T	Speech audiometry threshold, automated;	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0211T	Speech audiometry threshold, automated; with speech	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	recognition	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0219T	Placement of a posterior intrafacet implant(s), unilateral or	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	bilateral, including imaging and placement of bone graft(s) or	by the Plan. Not subject to pre-service		
	synthetic device(s), single level; cervical	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0220T	Placement of a posterior intrafacet implant(s), unilateral or	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	bilateral, including imaging and placement of bone graft(s) or	by the Plan. Not subject to pre-service		
	synthetic device(s), single level; thoracic	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0221T	Placement of a posterior intrafacet implant(s), unilateral or	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	bilateral, including imaging and placement of bone graft(s) or	by the Plan. Not subject to pre-service		
	synthetic device(s), single level; lumbar	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0222T	Placement of a posterior intrafacet implant(s), unilateral or	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	bilateral, including imaging and placement of bone graft(s) or	by the Plan. Not subject to pre-service		
	synthetic device(s), single level; each additional vertebral	review. Check EIU policy, which is one of		
	segment (List separately in addition to code for primary	our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
0224U	Antibody, severe acute respiratory syndrome coronavirus 2	EIU: Procedure/service not reimbursed	6/1/2023	12/31/2999
	(SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s),	by the Plan. Not subject to pre-service		
	when performed	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0226U	Surrogate viral neutralization test (sVNT), severe acute	EIU: Procedure/service not reimbursed	6/1/2023	12/31/2999
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus	by the Plan. Not subject to pre-service		
	disease [COVID-19]), ELISA, plasma, seru	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0232T	Injection(s), platelet rich plasma, any site, including image	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	guidance, harvesting and preparation when performed	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0253T	Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed	1/1/2011	12/31/2999
	extraocular reservoir, internal approach, into the suprachoroidal	against Medical Policy Criteria. Submit		
	space	for Recommended Clinical Review to		
		avoid post-service review.		
0263T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	by the Plan. Not subject to pre-service		
	including ultrasound guidance, if performed; complete procedure	review. Check EIU policy, which is one of		
	including unilateral or bilateral bone marrow harvest	our Clinical Payment and Coding Policy		
		(CPCP).		
0264T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	by the Plan. Not subject to pre-service		
	including ultrasound guidance, if performed; complete procedure	review. Check EIU policy, which is one of		
	excluding bone marrow harvest	our Clinical Payment and Coding Policy		
		(CPCP).		
0265T	Intramuscular autologous bone marrow cell therapy, with	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	preparation of harvested cells, multiple injections, one leg,	by the Plan. Not subject to pre-service		
	including ultrasound guidance, if performed; unilateral or	review. Check EIU policy, which is one of		
	bilateral bone marrow harvest only for intramuscular autologous	our Clinical Payment and Coding Policy		
	bone marrow cell therapy	(CPCP).		
0266T	Implantation or replacement of carotid sinus baroreflex	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	activation device; total system (includes generator placement,	against Medical Policy Criteria. Submit		
	unilateral or bilateral lead placement, intra-operative	for Recommended Clinical Review to		
	interrogation, programming, and repositioning, when performed)	avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, 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
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, 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
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, 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
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, 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
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, 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
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day);	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0273T	Interrogation device evaluation (in person), carotid sinus	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	baroreflex activation system, including telemetric iterative	against Medical Policy Criteria. Submit		
	communication with the implantable device to monitor device	for Recommended Clinical Review to		
	diagnostics and programmed therapy values, with interpretation	avoid post-service review.		
	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)	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	for decompression of neural elements, (with or without	by the Plan. Not subject to pre-service		
	ligamentous resection, discectomy, facetectomy and/or	review. Check EIU policy, which is one of		
	foraminotomy), any method, under indirect image guidance (eg,	our Clinical Payment and Coding Policy		
	fluoroscopic, CT), single or multiple levels, unilateral or bilateral;	(CPCP).		
	cervical or thoracic			
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach)	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	for decompression of neural elements, (with or without	by the Plan. Not subject to pre-service		
	ligamentous resection, discectomy, facetectomy and/or	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
	fluoroscopic, CT), single or multiple levels, unilateral or bilateral;	(CPCP).		
	lumbar			
0278T	Transcutaneous electrical modulation pain reprocessing (eg,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
	of electrodes)	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0308T	Insertion of ocular telescope prosthesis including removal of	MP Criteria: Procedure/service reviewed	7/1/2012	12/31/2999
	crystalline lens or intraocular lens prosthesis	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0312U	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment	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).	5/15/2025	12/31/2999
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	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).	1/15/2024	12/31/2999
0323U	Infectious agent detection by nucleic acid (DNA and RNA), central nervous system pathogen, metagenomic next-generation sequencing, cerebrospinal fluid (CSF), identification of pathogenic bacteria, viruses, parasites, or fungi	against Medical Policy Criteria. Submit	7/1/2022	12/31/2999
0329Т	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	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
0330T	Tear film imaging, unilateral or bilateral, 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).	9/1/2020	12/31/2999
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	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
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 Coding Policy (CPCP).	12/1/2020	12/31/2999
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and 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	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	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
0339Т	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; 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).	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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
0345T		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	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	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
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(ies), (includes shoulder, elbow, and wrist, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	Ending Date
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, 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
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	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
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	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
0353T	Optical coherence tomography of breast, surgical cavity; real- time intraoperative	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
0358T	Bioelectrical impedance analysis whole body composition assessment, 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).	12/1/2020	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report 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).	12/1/2020	12/31/2999
0379Т	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed 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).	12/1/2020	12/31/2999
0397Т	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (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).	1/1/2016	12/31/2999
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
0407U	Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported as risk for progressive decline in kidney function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0407U	Nephrology (diabetic chronic kidney disease [CKD]), multiplex	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
	electrochemiluminescent immunoassay (ECLIA) of soluble tumor	by the Plan. Not subject to pre-service		
	necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis	review. Check EIU policy, which is one of		
	receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1)	our Clinical Payment and Coding Policy		
	combined with clinical data, plasma, algorithm reported as risk	(CPCP).		
	for progressive decline in kidney function			
0408T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	modulation system, including contractility evaluation when	against Medical Policy Criteria. Submit		
	performed, and programming of sensing and therapeutic	for Recommended Clinical Review to		
	parameters; pulse generator with transvenous electrodes	avoid post-service review.		
0409T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	modulation system, including contractility evaluation when	against Medical Policy Criteria. Submit		
	performed, and programming of sensing and therapeutic	for Recommended Clinical Review to		
	parameters; pulse generator only	avoid post-service review.		
0410T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	modulation system, including contractility evaluation when	against Medical Policy Criteria. Submit		
	performed, and programming of sensing and therapeutic	for Recommended Clinical Review to		
	parameters; atrial electrode only	avoid post-service review.		
0411T	Insertion or replacement of permanent cardiac contractility	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	modulation system, including contractility evaluation when	against Medical Policy Criteria. Submit		
	performed, and programming of sensing and therapeutic	for Recommended Clinical Review to		
	parameters; ventricular electrode only	avoid post-service review.		
0412T	Removal of permanent cardiac contractility modulation system;	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	pulse generator only	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	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
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	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
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	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
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	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
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	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
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas	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
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas	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
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	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
0436U	Oncology (lung), plasma analysis of 388 proteins, using aptamer- based proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy	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
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance;	MP Criteria: Procedure/service reviewed	11/15/2019	12/31/2999
	lower extremity distal/peripheral nerve	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance;	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	nerve plexus or other truncal nerve (eg, brachial plexus,	against Medical Policy Criteria. Submit		
	pudendal nerve)	for Recommended Clinical Review to		
		avoid post-service review.		
0443T	Real-time spectral analysis of prostate tissue by fluorescence	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	spectroscopy, including imaging guidance (List separately in	against Medical Policy Criteria. Submit		
	addition to code for primary procedure)	for Recommended Clinical Review to		
		avoid post-service review.		
0444U	Oncology (solid organ neoplasia), targeted genomic sequence	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
	analysis panel of 361 genes, interrogation for gene fusions,	against Medical Policy Criteria. Submit		
	translocations, or other rearrangements, using DNA from	for Recommended Clinical Review to		
	formalin-fixed paraffin-embedded (FFPE) tumor tissue, report of	avoid post-service review.		
	clinically significant variant(s)			
0446U	Autoimmune diseases (systemic lupus erythematosus [SLE]),	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
	analysis of 10 cytokine soluble mediator biomarkers by	against Medical Policy Criteria. Submit		
	immunoassay, plasma, individual components reported with an	for Recommended Clinical Review to		
	algorithmic risk score for current disease activity	avoid post-service review.		
0447U	Autoimmune diseases (systemic lupus erythematosus [SLE]),	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
	analysis of 11 cytokine soluble mediator biomarkers by	against Medical Policy Criteria. Submit		
	immunoassay, plasma, individual components reported with an	for Recommended Clinical Review to		
	algorithmic prognostic risk score for developing a clinical flare	avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
0449U	Carrier screening for severe inherited conditions (eg, cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia), regardless of race or self-identified ancestry, genomic sequence analysis panel, must include analysis of 5 genes (CFTR, SMN1, HBB, HBA1, HBA2)	<u> </u>	4/1/2024	12/31/2999
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (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.	9/1/2020	12/31/2999
0464T	Visual evoked potential, testing for glaucoma, 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).	12/1/2020	12/31/2999
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2017	12/31/2999
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, 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
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	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
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	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
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; 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).	12/1/2020	12/31/2999
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2022	12/31/2999
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0490U	Oncology (cutaneous or uveal melanoma), circulating tumor cell	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	selection, morphological characterization and enumeration	against Medical Policy Criteria. Submit		
	based on differential CD146, high molecular-weight melanoma-	for Recommended Clinical Review to		
	associated antigen, CD34 and CD45 protein biomarkers,	avoid post-service review.		
	peripheral blood			
0491U	Oncology (solid tumor), circulating tumor cell selection,	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	morphological characterization and enumeration based on	against Medical Policy Criteria. Submit		
	differential epithelial cell adhesion molecule (EpCAM),	for Recommended Clinical Review to		
	cytokeratins 8, 18, and 19, CD45 protein biomarkers, and	avoid post-service review.		
	quantification of estrogen receptor (ER) protein biomarker-			
	expressing cells, peripheral blood			
0492U	Oncology (solid tumor), circulating tumor cell selection,	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	morphological characterization and enumeration based on	against Medical Policy Criteria. Submit		
	differential epithelial cell adhesion molecule (EpCAM),	for Recommended Clinical Review to		
	cytokeratins 8, 18, and 19, CD45 protein biomarkers, and	avoid post-service review.		
	quantification of PD-L1 protein biomarker-expressing cells,			
	peripheral blood			
0494T	Surgical preparation and cannulation of marginal (extended)	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	cadaver donor lung(s) to ex vivo organ perfusion system,	against Medical Policy Criteria. Submit		
	including decannulation, separation from the perfusion system,	for Recommended Clinical Review to		
	and cold preservation of the allograft prior to implantation, when	avoid post-service review.		
	performed			
0495T	Initiation and monitoring marginal (extended) cadaver donor	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	lung(s) organ perfusion system by physician or qualified health	against Medical Policy Criteria. Submit		
	care professional, including physiological and laboratory	for Recommended Clinical Review to		
	assessment (eg, pulmonary artery flow, pulmonary artery	avoid post-service review.		
	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			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer		10/1/2024	12/31/2999
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including 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)	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
0501U	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)	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
0507T	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, 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).	7/1/2018	12/31/2999
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0510T	Removal of sinus tarsi implant	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
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype	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
0511T	Removal and reinsertion 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 Coding Policy (CPCP).	12/1/2020	12/31/2999
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	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
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	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).	1/1/2019	12/31/2999
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (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).	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0514U	Gastroenterology (irritable bowel disease [IBD]), immunoassay	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	for quantitative determination of adalimumab (ADL) levels in	against Medical Policy Criteria. Submit		
	venous serum in patients undergoing adalimumab therapy,	for Recommended Clinical Review to		
	results reported as a numerical value as micrograms per milliliter	avoid post-service review.		
	(ug/mL)			
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing,	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	including device interrogation and programming, and imaging	against Medical Policy Criteria. Submit		
	supervision and interpretation, when performed; complete	for Recommended Clinical Review to		
	system (includes electrode and generator [transmitter and	avoid post-service review.		
	battery])			
0515U	Gastroenterology (irritable bowel disease [IBD]), immunoassay	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	for quantitative determination of infliximab (IFX) levels in venous	against Medical Policy Criteria. Submit		
	serum in patients undergoing infliximab therapy, results reported	for Recommended Clinical Review to		
	as a numerical value as micrograms per milliliter (ug/mL)	avoid post-service review.		
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing,	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	including device interrogation and programming, and imaging	against Medical Policy Criteria. Submit		
	supervision and interpretation, when performed; electrode only	for Recommended Clinical Review to		
		avoid post-service review.		
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing,	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	including device interrogation and programming, and imaging	against Medical Policy Criteria. Submit		
	supervision and interpretation, when performed; both	for Recommended Clinical Review to		
	components of pulse generator (battery and transmitter) only	avoid post-service review.		
0518T	Removal of pulse generator for wireless cardiac stimulator for	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	left ventricular pacing; battery component only	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit	9/1/2020	12/31/2999
	interrogation and programming; both components (battery and	for Recommended Clinical Review to		
	transmitter)	avoid post-service review.		
0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	against Medical Policy Criteria. Submit for Recommended Clinical Review to	9/1/2020	12/31/2999
0521T	Interrogation device evaluation (in person) with analysis, review	avoid post-service review.  MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	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
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	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
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	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
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	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
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	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
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	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
0529U	Hematology (venous thromboembolism [VTE]), genome-wide single-nucleotide polymorphism variants, including F2 and F5 gene analysis, and Leiden variant, by microarray analysis, saliva, report as risk score for VTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	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
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only		9/1/2020	12/31/2999
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	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
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, 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
0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	7/1/2019	12/31/2999
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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2024	12/31/2999
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (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.	11/1/2024	12/31/2999
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, 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).	12/1/2020	12/31/2999
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	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
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	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
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (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.	9/1/2023	12/31/2999
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0572T	Insertion of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0573T	Removal of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent 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.	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0576T	Interrogation device evaluation (in person) of implantable	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	cardioverter-defibrillator system with substernal electrode, with	against Medical Policy Criteria. Submit		
	analysis, review and report by a physician or other qualified	for Recommended Clinical Review to		
	health care professional, includes connection, recording and	avoid post-service review.		
	disconnection per patient encounter			
0577T	Electrophysiologic evaluation of implantable cardioverter-	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	defibrillator system with substernal electrode (includes	against Medical Policy Criteria. Submit		
	defibrillation threshold evaluation, induction of arrhythmia,	for Recommended Clinical Review to		
	evaluation of sensing for arrhythmia termination, and	avoid post-service review.		
	programming or reprogramming of sensing or therapeutic			
	parameters)			
0578T	Interrogation device evaluation(s) (remote), up to 90 days,	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	substernal lead implantable cardioverter-defibrillator system	against Medical Policy Criteria. Submit		
	with interim analysis, review(s) and report(s) by a physician or	for Recommended Clinical Review to		
	other qualified health care professional	avoid post-service review.		
0579T	Interrogation device evaluation(s) (remote), up to 90 days,	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	substernal lead implantable cardioverter-defibrillator system,	against Medical Policy Criteria. Submit		
	remote data acquisition(s), receipt of transmissions and	for Recommended Clinical Review to		
	technician review, technical support and distribution of results	avoid post-service review.		
0580T	Removal of substernal implantable defibrillator pulse generator	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	only	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0587T	Percutaneous implantation or replacement of integrated single	MP Criteria: Procedure/service reviewed	3/1/2021	12/31/2999
	device neurostimulation system for bladder dysfunction including	against Medical Policy Criteria. Submit		
	electrode array and receiver or pulse generator, including	for Recommended Clinical Review to		
	analysis, programming, and imaging guidance when performed,	avoid post-service review.		
	posterior tibial nerve			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0588T	Revision or removal of percutaneously placed integrated single	MP Criteria: Procedure/service reviewed	3/1/2021	12/31/2999
	device neurostimulation system for bladder dysfunction including	against Medical Policy Criteria. Submit		
	electrode array and receiver or pulse generator, including	for Recommended Clinical Review to		
	analysis, programming, and imaging guidance when performed,	avoid post-service review.		
	posterior tibial nerve			
0589T	Electronic analysis with simple programming of implanted	MP Criteria: Procedure/service reviewed	3/1/2021	12/31/2999
	integrated neurostimulation system for bladder dysfunction (eg,	against Medical Policy Criteria. Submit		
	electrode array and receiver), including contact group(s),	for Recommended Clinical Review to		
	amplitude, pulse width, frequency (Hz), on/off cycling, burst,	avoid post-service review.		
	dose lockout, patient-selectable parameters, responsive			
	neurostimulation, detection algorithms, closed-loop parameters,			
	and passive parameters, when performed by physician or other			
	qualified health care professional, posterior tibial nerve, 1-3			
	parameters			
0590T	Electronic analysis with complex programming of implanted	MP Criteria: Procedure/service reviewed	3/1/2021	12/31/2999
	integrated neurostimulation system for bladder dysfunction (eg,	against Medical Policy Criteria. Submit		
	electrode array and receiver), including contact group(s),	for Recommended Clinical Review to		
	amplitude, pulse width, frequency (Hz), on/off cycling, burst,	avoid post-service review.		
	dose lockout, patient-selectable parameters, responsive			
	neurostimulation, detection algorithms, closed-loop parameters,			
	and passive parameters, when performed by physician or other			
	qualified health care professional, posterior tibial nerve, 4 or			
	more parameters			
0596T	Temporary female intraurethral valve-pump (ie, voiding	MP Criteria: Procedure/service reviewed	11/15/2023	12/31/2999
	prosthesis); initial insertion, including urethral measurement	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0597T	Temporary female intraurethral valve-pump (ie, voiding	MP Criteria: Procedure/service reviewed	11/15/2023	12/31/2999
	prosthesis); replacement	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
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Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	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
0599Т	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (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).	10/1/2024	12/31/2999
0600Т	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	· ·	4/1/2021	12/31/2999
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	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).	4/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0615T	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, 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).	5/15/2021	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, 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).	7/1/2024	12/31/2999
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, 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).	1/1/2021	12/31/2999
0621T	Trabeculostomy ab interno by laser;	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).	1/1/2021	12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	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).	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, 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).	1/1/2021	12/31/2999
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	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).	1/1/2021	12/31/2999
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	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).	1/1/2021	12/31/2999
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, 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).	1/1/2021	12/31/2999
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	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).	1/1/2021	12/31/2999
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (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).	1/1/2021	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based	EIU: Procedure/service not reimbursed	1/1/2021	12/31/2999
	product, intervertebral disc, unilateral or bilateral injection, with	by the Plan. Not subject to pre-service		
	CT guidance, lumbar; first level	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based	EIU: Procedure/service not reimbursed	1/1/2021	12/31/2999
		by the Plan. Not subject to pre-service		
	CT guidance, lumbar; each additional level (List separately in	review. Check EIU policy, which is one of		
	addition to code for primary procedure)	our Clinical Payment and Coding Policy		
		(CPCP).		
0631T	Transcutaneous visible light hyperspectral imaging measurement	EIU: Procedure/service not reimbursed	1/1/2021	12/31/2999
	of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation,	by the Plan. Not subject to pre-service		
	with interpretation and report, per extremity	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0632T	Percutaneous transcatheter ultrasound ablation of nerves	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	innervating the pulmonary arteries, including right heart	against Medical Policy Criteria. Submit		
	catheterization, pulmonary artery angiography, and all imaging	for Recommended Clinical Review to		
	guidance	avoid post-service review.		
0639T	Wireless skin sensor thermal anisotropy measurement(s) and	EIU: Procedure/service not reimbursed	1/1/2021	12/31/2999
	assessment of flow in cerebrospinal fluid shunt, including	by the Plan. Not subject to pre-service		
	ultrasound guidance, when performed	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0640Т	, , , , ,	EIU: Procedure/service not reimbursed	7/1/2021	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue	by the Plan. Not subject to pre-service		
	oxygenation), other than for screening for peripheral arterial	review. Check EIU policy, which is one of		
	disease, image acquisition, interpretation, and report; first	our Clinical Payment and Coding Policy		
	anatomic site	(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0643T	Transcatheter left ventricular restoration device implantation	MP Criteria: Procedure/service reviewed	7/1/2021	12/31/2999
	including right and left heart catheterization and left	against Medical Policy Criteria. Submit		
	ventriculography when performed, arterial approach	for Recommended Clinical Review to		
		avoid post-service review.		
0645T	Transcatheter implantation of coronary sinus reduction device	MP Criteria: Procedure/service reviewed	7/1/2021	12/31/2999
	including vascular access and closure, right heart catheterization,	against Medical Policy Criteria. Submit		
	venous angiography, coronary sinus angiography, imaging	for Recommended Clinical Review to		
	guidance, and supervision and interpretation, when performed	avoid post-service review.		
0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement	MP Criteria: Procedure/service reviewed	7/1/2021	12/31/2999
	with prosthetic valve, percutaneous approach, including right	against Medical Policy Criteria. Submit		
	heart catheterization, temporary pacemaker insertion, and	for Recommended Clinical Review to		
	selective right ventricular or right atrial angiography, when	avoid post-service review.		
	performed			
0650T	Programming device evaluation (remote) of subcutaneous	MP Criteria: Procedure/service reviewed	7/1/2021	12/31/2999
		against Medical Policy Criteria. Submit		
	implantable device to test the function of the device and select	for Recommended Clinical Review to		
	optimal permanently programmed values with analysis, review	avoid post-service review.		
	and report by a physician or other qualified health care			
	professional			
0651T	Magnetically controlled capsule endoscopy, esophagus through	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	stomach, including intraprocedural positioning of capsule, with	by the Plan. Not subject to pre-service		
	interpretation and report	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up	EIU: Procedure/service not reimbursed	7/1/2021	12/31/2999
	to 7 vertebral segments	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more 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).	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
0659Т	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation		3/1/2025	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
0665T	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
0666T	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0667T	Donor hysterectomy (including cold preservation); recipient	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	uterus allograft transplantation from cadaver or living donor	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0668T	Backbench standard preparation of cadaver or living donor	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	uterine allograft prior to transplantation, including dissection and	by the Plan. Not subject to pre-service		
	removal of surrounding soft tissues and preparation of uterine	review. Check EIU policy, which is one of		
	vein(s) and uterine artery(ies), as necessary	our Clinical Payment and Coding Policy		
		(CPCP).		
0669T	Backbench reconstruction of cadaver or living donor uterus	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	allograft prior to transplantation; venous anastomosis, each	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0670T	Backbench reconstruction of cadaver or living donor uterus	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	allograft prior to transplantation; arterial anastomosis, each	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0672T		EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
	and proximal urethra for urinary incontinence	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
0692T	Therapeutic ultrafiltration	MP Criteria: Procedure/service reviewed	5/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing, and concentration of ADRCs	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging		7/1/2022	12/31/2999
0722Т		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (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.	7/1/2022	12/31/2999
0725T	Vestibular device implantation, unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0726Т	Removal of implanted vestibular device, unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0727Т	Removal and replacement of implanted vestibular device, unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0731T	Augmentative AI-based facial phenotype analysis with report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0732T	Immunotherapy administration with electroporation, intramuscular	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0734T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (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.	7/1/2022	12/31/2999
0737T	Xenograft implantation into the articular surface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	1/1/2023	12/31/2999
0744T		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
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	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
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	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)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0764T	Assistive algorithmic electrocardiogram risk-based assessment	MP Criteria: Procedure/service reviewed	6/15/2023	12/31/2999
	for cardiac dysfunction (eg, low-ejection fraction, pulmonary	against Medical Policy Criteria. Submit		
	hypertension, hypertrophic cardiomyopathy); related to	for Recommended Clinical Review to		
	concurrently performed electrocardiogram (List separately in	avoid post-service review.		
	addition to code for primary procedure)			
0765T	Assistive algorithmic electrocardiogram risk-based assessment	MP Criteria: Procedure/service reviewed	6/15/2023	12/31/2999
	for cardiac dysfunction (eg, low-ejection fraction, pulmonary	against Medical Policy Criteria. Submit		
	hypertension, hypertrophic cardiomyopathy); related to	for Recommended Clinical Review to		
	previously performed electrocardiogram	avoid post-service review.		
0766T	Transcutaneous magnetic stimulation by focused low-frequency	EIU: Procedure/service not reimbursed	7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	by the Plan. Not subject to pre-service		
	marking of the treatment location, including noninvasive	review. Check EIU policy, which is one of		
	electroneurographic localization (nerve conduction localization),	our Clinical Payment and Coding Policy		
	when performed; first nerve	(CPCP).		
0767T	Transcutaneous magnetic stimulation by focused low-frequency	EIU: Procedure/service not reimbursed	7/1/2023	12/31/2999
	electromagnetic pulse, peripheral nerve, with identification and	by the Plan. Not subject to pre-service		
	marking of the treatment location, including noninvasive	review. Check EIU policy, which is one of		
	electroneurographic localization (nerve conduction localization),	our Clinical Payment and Coding Policy		
	when performed; each additional nerve (List separately in	(CPCP).		
	addition to code for primary procedure)			
0770T	Virtual reality technology to assist therapy (List separately in	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
0,701	addition to code for primary procedure)	by the Plan. Not subject to pre-service	5/ 1/2023	12,31,2333
	addition to code for primary procedure,	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
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Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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	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	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		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
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0776T	Therapeutic induction of intra-brain hypothermia, including	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
	placement of a mechanical temperature-controlled cooling	by the Plan. Not subject to pre-service		
	device to the neck over carotids and head, including monitoring	review. Check EIU policy, which is one of		
	(eg, vital signs and sport concussion assessment tool 5 [SCAT5]),	our Clinical Payment and Coding Policy		
	30 minutes of treatment	(CPCP).		
0777T	Real-time pressure-sensing epidural guidance system (List	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
	separately in addition to code for primary procedure)	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	
0778T	Surface mechanomyography (sMMG) with concurrent application		9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
	multi-joint range of motion, posture, gait, and muscle function	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).	0 /4 /0 000	10/01/0000
0779T	Gastrointestinal myoelectrical activity study, stomach through	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
	colon, with interpretation and report	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy (CPCP).		
0780T	Instillation of fecal microbiota suspension via rectal enema into	MP Criteria: Procedure/service reviewed	1/1/2022	12/31/2999
07801	lower gastrointestinal tract	against Medical Policy Criteria. Submit	1/1/2023	12/31/2999
	lower gastrollitestillar tract	for Recommended Clinical Review to		
		avoid post-service review.		
		avoid post-service review.		
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
	protection device and circumferential radiofrequency destruction		, ,	, , , , , , , , , , , , , , , , , , , ,
	of the pulmonary nerves, including fluoroscopic guidance when	review. Check EIU policy, which is one of		
	performed; bilateral mainstem bronchi	our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when	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	9/1/2023	12/31/2999
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	(CPCP).  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
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed		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 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
0787T	, ,	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters	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
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	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
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, 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
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (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
0792Т	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional	,	7/1/2023	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0793Т	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	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
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately	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
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	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
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	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
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0798T	Transcatheter removal of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous	against Medical Policy Criteria. Submit		
	ultrasound, right atrial angiography, right ventriculography,	for Recommended Clinical Review to		
	femoral venography), when performed; complete system (ie,	avoid post-service review.		
	right atrial and right ventricular pacemaker components)			
0799T	Transcatheter removal of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous	against Medical Policy Criteria. Submit		
	ultrasound, right atrial angiography, right ventriculography,	for Recommended Clinical Review to		
	femoral venography), when performed; right atrial pacemaker component	avoid post-service review.		
0800T	Transcatheter removal of permanent dual-chamber leadless	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	pacemaker, including imaging guidance (eg, fluoroscopy, venous	against Medical Policy Criteria. Submit		
	ultrasound, right atrial angiography, right ventriculography,	for Recommended Clinical Review to		
	femoral venography), when performed; right ventricular	avoid post-service review.		
	pacemaker component (when part of a dual-chamber leadless			
	pacemaker system)			
0801T	Transcatheter removal and replacement of permanent dual-	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	chamber leadless pacemaker, including imaging guidance (eg,	against Medical Policy Criteria. Submit		
	fluoroscopy, venous ultrasound, right atrial angiography, right	for Recommended Clinical Review to		
	ventriculography, femoral venography) and device evaluation	avoid post-service review.		
	(eg, interrogation or programming), when performed; dual-			
	chamber system (ie, right atrial and right ventricular pacemaker			
	components)			
0802T	Transcatheter removal and replacement of permanent dual-	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	chamber leadless pacemaker, including imaging guidance (eg,	against Medical Policy Criteria. Submit		
	fluoroscopy, venous ultrasound, right atrial angiography, right	for Recommended Clinical Review to		
	ventriculography, femoral venography) and device evaluation	avoid post-service review.		
	(eg, interrogation or programming), when performed; right atrial			
	pacemaker component			

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	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
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	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
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	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
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	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
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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	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
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 preservice review.	1/1/2024	12/31/2999
0812T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	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; 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	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, 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
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 Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0822T	Continuous in-person monitoring and intervention (eg,	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	psychotherapy, crisis intervention), as needed, during	against Medical Policy Criteria. Submit		
	psychedelic medication therapy; clinical staff under the direction	for Recommended Clinical Review to		
	of a physician or other qualified health care professional,	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	MP Criteria: Procedure/service reviewed	5/15/2024	12/31/2999
	pacemaker, right atrial, including imaging guidance (eg,	against Medical Policy Criteria. Submit		
	fluoroscopy, venous ultrasound, right atrial angiography and/or	for Recommended Clinical Review to		
	right ventriculography, femoral venography, cavography) and	avoid post-service review.		
	device evaluation (eg, interrogation or programming), when			
	performed			
0824T	Transcatheter removal of permanent single-chamber leadless	MP Criteria: Procedure/service reviewed	5/15/2024	12/31/2999
	pacemaker, right atrial, including imaging guidance (eg,	against Medical Policy Criteria. Submit		
	fluoroscopy, venous ultrasound, right atrial angiography and/or	for Recommended Clinical Review to		
	right ventriculography, femoral venography, cavography), when	avoid post-service review.		
	performed			
0825T	Transcatheter removal and replacement of permanent single-	MP Criteria: Procedure/service reviewed	5/15/2024	12/31/2999
	chamber leadless pacemaker, right atrial, including imaging	against Medical Policy Criteria. Submit		
	guidance (eg, fluoroscopy, venous ultrasound, right atrial	for Recommended Clinical Review to		
	angiography and/or right ventriculography, femoral venography,	avoid post-service review.		
	cavography) and device evaluation (eg, interrogation or			
	programming), when performed			
0826T	Programming device evaluation (in person) with iterative	MP Criteria: Procedure/service reviewed	5/15/2024	12/31/2999
	adjustment of the implantable device to test the function of the	against Medical Policy Criteria. Submit		
	device and select optimal permanent programmed values with	for Recommended Clinical Review to		
	analysis, review and report by a physician or other qualified	avoid post-service review.		
	health care professional, leadless pacemaker system in single-			
	cardiac chamber			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0857T	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (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
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated 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).	10/1/2024	12/31/2999
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	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
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	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
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	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
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	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
0866Т	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (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
0868T	High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0870T		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, 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).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, 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).	5/15/2025	12/31/2999
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, 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).	5/15/2025	12/31/2999
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, 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).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	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).	5/15/2025	12/31/2999
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by 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.	9/1/2024	5/14/2025
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by 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).	5/15/2025	12/31/2999
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0901T	Placement of bone marrow sampling port, including imaging guidance when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0906T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0907T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm (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.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0908T	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0909Т	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0910T	Removal of integrated neurostimulation system, vagus nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0911T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by 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.	1/1/2025	12/31/2999
0912T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by 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.	1/1/2025	12/31/2999
0915T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator and dual transvenous electrodes/leads (pacing and defibrillation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0916T	Insertion of permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s), including fluoroscopic	against Medical Policy Criteria. Submit		
	guidance, and evaluation and programming of sensing and	for Recommended Clinical Review to		
	therapeutic parameters; pulse generator only	avoid post-service review.		
0917T	Insertion of permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s), including fluoroscopic	against Medical Policy Criteria. Submit		
	guidance, and evaluation and programming of sensing and	for Recommended Clinical Review to		
	therapeutic parameters; single transvenous lead (pacing or defibrillation) only	avoid post-service review.		
0918T	Insertion of permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s), including fluoroscopic	against Medical Policy Criteria. Submit		
	guidance, and evaluation and programming of sensing and	for Recommended Clinical Review to		
	therapeutic parameters; dual transvenous leads (pacing and	avoid post-service review.		
	defibrillation) only			
0919T	Removal of a permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s); pulse generator only	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
0920T	Removal of a permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s); single transvenous pacing	against Medical Policy Criteria. Submit		
	lead only	for Recommended Clinical Review to		
		avoid post-service review.		
0921T	Removal of a permanent cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillation system component(s); single transvenous	against Medical Policy Criteria. Submit		
	defibrillation lead only	for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0922T	Removal of a permanent cardiac contractility modulation- defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0923T	Removal and replacement of permanent cardiac contractility modulation defibrillation pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0924T	Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0925T	Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0926T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation-defibrillation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0927T	Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
0928T	Interrogation device evaluation (remote), up to 90 days, cardiac	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	contractility modulation-defibrillation system with interim	against Medical Policy Criteria. Submit		
	analysis and report(s) by a physician or other qualified health	for Recommended Clinical Review to		
	care professional	avoid post-service review.		
0929T	Interrogation device evaluation (remote), up to 90 days, cardiac	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	contractility modulation-defibrillation system, remote data	against Medical Policy Criteria. Submit		
	acquisition(s), receipt of transmissions, technician review,	for Recommended Clinical Review to		
	technical support, and distribution of results	avoid post-service review.		
0930T	Electrophysiologic evaluation of cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillator leads, including defibrillation-threshold evaluation	against Medical Policy Criteria. Submit		
	(induction of arrhythmia, evaluation of sensing and therapy for	for Recommended Clinical Review to		
	arrhythmia termination), at time of initial implantation or	avoid post-service review.		
	replacement with testing of cardiac contractility modulation-			
	defibrillator pulse generator			
0931T	Electrophysiologic evaluation of cardiac contractility modulation-	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	defibrillator leads, including defibrillation-threshold evaluation	against Medical Policy Criteria. Submit		
	(induction of arrhythmia, evaluation of sensing and therapy for	for Recommended Clinical Review to		
	arrhythmia termination), separate from initial implantation or	avoid post-service review.		
	replacement with testing of cardiac contractility modulation			
	defibrillator pulse generator			
0932T	Noninvasive detection of heart failure derived from	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	augmentative analysis of an echocardiogram that demonstrated	against Medical Policy Criteria. Submit		
	preserved ejection fraction, with interpretation and report by a	for Recommended Clinical Review to		
	physician or other qualified health care professional	avoid post-service review.		
0933T	Transcatheter implantation of wireless left atrial pressure sensor	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	for long-term left atrial pressure monitoring, including sensor	against Medical Policy Criteria. Submit		
	calibration and deployment, right heart catheterization,	for Recommended Clinical Review to		
	transseptal puncture, imaging guidance, and radiological	avoid post-service review.		
	supervision and interpretation			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0934T	Remote monitoring of a wireless left atrial pressure sensor for up to 30 days, including data from daily uploads of left atrial pressure recordings, interpretation(s) and trend analysis, with adjustments to the diuretics plan, treatment paradigm thresholds, medications or lifestyle modifications, when performed, and report(s) 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.	1/1/2025	12/31/2999
0935T	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0936T	Photobiomodulation therapy of retina, single session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0937T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording, scanning analysis with report, review and interpretation 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.	1/1/2025	12/31/2999
0938T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0939Т	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
0940T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; Review and interpretation 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.	1/1/2025	12/31/2999
0941T	Cystourethroscopy, flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0942Т	Cystourethroscopy, flexible; with removal and replacement of prostatic urethral scaffold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0943T	Cystourethroscopy, flexible; with removal of prostatic urethral scaffold	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0947T	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
9701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	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
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (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.	9/24/2012	12/31/2999
11719	Trimming of nondystrophic nails, any number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	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
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	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
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (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.	4/1/2009	12/31/2999
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	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
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	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
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	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
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	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
11980	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 Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
11981	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)	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
11982	Removal, non-biodegradable drug delivery implant	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
11983	Removal with reinsertion, non-biodegradable drug delivery implant	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
15011	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
15012	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less; each additional 25 sq cm or part therof (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.	1/1/2025	12/31/2999
15013	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
15014	'	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
15015		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
15016		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
15017	sites, including application of primary dressing, face, scalp,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
15018	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (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.	1/1/2025	12/31/2999
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	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
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (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.	4/1/2023	12/31/2999
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	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
15274	Application of skin substitute graft to trunk, arms, legs, 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 infants and children, or part thereof (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.	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	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
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (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.	4/1/2023	12/31/2999
15277	Application of 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; first 100 sq cm wound surface area, or 1% of body area of infants and children		4/1/2023	12/31/2999
15278	Application of 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 infants and children, or part thereof (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.	4/1/2023	12/31/2999
15758	Free fascial flap with microvascular anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2010	12/31/2999
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (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.	1/15/2021	12/31/2999
15775	Punch graft for hair transplant; 1 to 15 punch grafts	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
15776	Punch graft for hair transplant; more than 15 punch grafts	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
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	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
15781	Dermabrasion; segmental, face	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
15782	Dermabrasion; regional, other than face	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	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
15786	Abrasion; single lesion (eg, keratosis, scar)	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
15787	Abrasion; each additional 4 lesions or less (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.	4/1/2009	12/31/2999
15788	Chemical peel, facial; epidermal	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
15789	Chemical peel, facial; dermal	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
15792	Chemical peel, nonfacial; epidermal	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
15793	Chemical peel, nonfacial; dermal	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
15820	Blepharoplasty, lower eyelid;	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
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	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
15822	Blepharoplasty, upper eyelid;	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
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	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
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
15828	Rhytidectomy; cheek, chin, and neck	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
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	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
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	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
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	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
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	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
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	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
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	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
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	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
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	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
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	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
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (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.	4/1/2009	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
15876	Suction assisted lipectomy; head and neck	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
15877	Suction assisted lipectomy; trunk	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
15878	Suction assisted lipectomy; upper extremity	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
15879	Suction assisted lipectomy; lower extremity	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
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	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
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	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
17340	Cryotherapy (CO2 slush, liquid N2) for acne	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
17360	Chemical exfoliation for acne (eg, acne paste, acid)	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
17380	Electrolysis epilation, each 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
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	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
19300	Mastectomy for gynecomastia	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed	1/1/2007	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
19325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
19328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
19330	Removal of ruptured breast implant, including implant contents	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	(eg, saline, silicone gel)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
19340	Insertion of breast implant on same day of mastectomy (ie,	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	immediate)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
19342	Insertion or replacement of breast implant on separate day from	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	mastectomy	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
19350	Nipple/areola reconstruction	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
19355	Correction of inverted nipples	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
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	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
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	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
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	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
19499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	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
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(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).	12/1/2020	12/31/2999
20561	Needle insertion(s) without injection(s); 3 or more muscles	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
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	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
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (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
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2013	12/31/2999
21083	Impression and custom preparation; palatal lift prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2007	12/31/2999
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	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
21121	Genioplasty; sliding osteotomy, single piece	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
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	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
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	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
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	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
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	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
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	12/31/2999
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2009	12/31/2999
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2007	12/31/2999
21740	Reconstructive repair of pectus excavatum or carinatum; open	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
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	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
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	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
22505	Manipulation of spine requiring anesthesia, any region	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	or bilateral including fluoroscopic guidance; single level	by the Plan. 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	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	or bilateral including fluoroscopic guidance; 1 or more additional	by the Plan. Not subject to pre-service		
	levels (List separately in addition to code for primary procedure)	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
22586	Arthrodesis, pre-sacral interbody technique, including disc space	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	preparation, discectomy, with posterior instrumentation, with	by the Plan. Not subject to pre-service		
	image guidance, includes bone graft when performed, L5-S1	review. Check EIU policy, which is one of		
	interspace	our Clinical Payment and Coding Policy		
		(CPCP).		
22836	Anterior thoracic vertebral body tethering, including	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	thoracoscopy, when performed; up to 7 vertebral segments	by the Plan. 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	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	thoracoscopy, when performed; 8 or more vertebral segments	by the Plan. 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	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	removal of thoracic vertebral body tethering, including	by the Plan. Not subject to pre-service		
	thoracoscopy, when performed	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
22867	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	stabilization/distraction device, without fusion, including image	by the Plan. Not subject to pre-service		
	guidance when performed, with open decompression, lumbar;	review. Check EIU policy, which is one of		
	single level	our Clinical Payment and Coding Policy		
		(CPCP).		
22868	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	stabilization/distraction device, without fusion, including image	by the Plan. Not subject to pre-service		
	guidance when performed, with open decompression, lumbar;	review. Check EIU policy, which is one of		
	second level (List separately in addition to code for primary	our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
22869	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	stabilization/distraction device, without open decompression or	by the Plan. Not subject to pre-service		
	fusion, including image guidance when performed, lumbar; single	review. Check EIU policy, which is one of		
	level	our Clinical Payment and Coding Policy		
		(CPCP).		
22870	Insertion of interlaminar/interspinous process	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	stabilization/distraction device, without open decompression or	by the Plan. Not subject to pre-service		
	fusion, including image guidance when performed, lumbar;	review. Check EIU policy, which is one of		
	second level (List separately in addition to code for primary	our Clinical Payment and Coding Policy		
	procedure)	(CPCP).		
22899	Unlisted procedure, spine	MP Criteria: Procedure/service reviewed	4/1/2023	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed	11/1/2017	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
27278	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	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
27299	Unlisted procedure, pelvis or hip joint	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
27702	Arthroplasty, ankle; with implant (total ankle)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2009	12/31/2999
27703	Arthroplasty, ankle; revision, total ankle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
27704	Removal of ankle implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	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
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	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
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	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
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
29916	Arthroscopy, hip, surgical; with labral repair	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
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(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).	5/15/2021	12/31/2999
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	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
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal 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).	5/15/2024	12/31/2999
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal 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).	5/15/2024	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	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
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	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
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	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
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	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
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (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.	12/1/2020	12/31/2999
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	5/14/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	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).	5/15/2025	12/31/2999
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	5/14/2025
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	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).	5/15/2025	12/31/2999
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, 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
32664	Thoracoscopy, surgical; with thoracic sympathectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2007	12/31/2999
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2009	12/31/2999
33213	Insertion of pacemaker pulse generator only; with existing dual leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2009	12/31/2999
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (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.	2/1/2009	12/31/2999
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	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
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (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.	10/1/2022	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	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
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	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
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
33277	Insertion of phrenic nerve stimulator transvenous sensing lead	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	(List separately in addition to code for primary procedure)	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
33278	Removal of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and	by the Plan. Not subject to pre-service		
	programming, when performed; system, including pulse	review. Check EIU policy, which is one of		
	generator and lead(s)	our Clinical Payment and Coding Policy		
		(CPCP).		
33279	Removal of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and	by the Plan. Not subject to pre-service		
	programming, when performed; transvenous stimulation or	review. Check EIU policy, which is one of		
	sensing lead(s) only	our Clinical Payment and Coding Policy		
		(CPCP).		
33280	Removal of phrenic nerve stimulator, including vessel	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	catheterization, all imaging guidance, and interrogation and	by the Plan. Not subject to pre-service		
	programming, when performed; pulse generator only	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
33285	Insertion, subcutaneous cardiac rhythm monitor, including	MP Criteria: Procedure/service reviewed	1/1/2019	12/31/2999
	programming	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
33287	Removal and replacement of phrenic nerve stimulator, including	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	by the Plan. Not subject to pre-service		
	and programming, when performed; pulse generator	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
33288	Removal and replacement of phrenic nerve stimulator, including	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	vessel catheterization, all imaging guidance, and interrogation	by the Plan. Not subject to pre-service		
	and programming, when performed; transvenous stimulation or	review. Check EIU policy, which is one of		
	sensing lead(s)	our Clinical Payment and Coding Policy		
		(CPCP).		
33289	Transcatheter implantation of wireless pulmonary artery	MP Criteria: Procedure/service reviewed	1/1/2019	12/31/2999
	pressure sensor for long-term hemodynamic monitoring,	against Medical Policy Criteria. Submit		
	including deployment and calibration of the sensor, right heart	for Recommended Clinical Review to		
	catheterization, selective pulmonary catheterization, radiological	avoid post-service review.		
	supervision and interpretation, and pulmonary artery			
	angiography, when performed			
33340	Percutaneous transcatheter closure of the left atrial appendage	MP Criteria: Procedure/service reviewed	1/1/2017	12/31/2999
	with endocardial implant, including fluoroscopy, transseptal	against Medical Policy Criteria. Submit		
	puncture, catheter placement(s), left atrial angiography, left	for Recommended Clinical Review to		
	atrial appendage angiography, when performed, and radiological	avoid post-service review.		
	supervision and interpretation			
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed	1/1/2013	12/31/2999
	prosthetic valve; percutaneous femoral artery approach	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed	1/1/2013	12/31/2999
	prosthetic valve; open femoral artery approach	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	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
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (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.	1/1/2013	12/31/2999
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (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.	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with	MP Criteria: Procedure/service reviewed	1/1/2013	12/31/2999
	prosthetic valve; cardiopulmonary bypass support with central	against Medical Policy Criteria. Submit		
	arterial and venous cannulation (eg, aorta, right atrium,	for Recommended Clinical Review to		
	pulmonary artery) (List separately in addition to code for primary	avoid post-service review.		
	procedure)			
33370	Transcatheter placement and subsequent removal of cerebral	MP Criteria: Procedure/service reviewed	2/15/2025	12/31/2999
	embolic protection device(s), including arterial access,	against Medical Policy Criteria. Submit		
	catheterization, imaging, and radiological supervision and	for Recommended Clinical Review to		
	interpretation, percutaneous (List separately in addition to code	avoid post-service review.		
	for primary procedure)			
33418	Transcatheter mitral valve repair, percutaneous approach,	MP Criteria: Procedure/service reviewed	2/15/2016	12/31/2999
	including transseptal puncture when performed; initial prosthesis	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
33419	Transcatheter mitral valve repair, percutaneous approach,	MP Criteria: Procedure/service reviewed	2/15/2016	12/31/2999
	including transseptal puncture when performed; additional	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
	code for primary procedure)	avoid post-service review.		
33477	Transcatheter pulmonary valve implantation, percutaneous	MP Criteria: Procedure/service reviewed	1/1/2016	12/31/2999
	approach, including pre-stenting of the valve delivery site, when	against Medical Policy Criteria. Submit		
	performed	for Recommended Clinical Review to		
		avoid post-service review.		
33883	Placement of proximal extension prosthesis for endovascular	MP Criteria: Procedure/service reviewed	1/1/2006	12/31/2999
	repair of descending thoracic aorta (eg, aneurysm,	against Medical Policy Criteria. Submit	1, 1, 2000	12/31/2333
	pseudoaneurysm, dissection, penetrating ulcer, intramural	for Recommended Clinical Review to		
	hematoma, or traumatic disruption); initial extension	avoid post-service review.		
	mematoma, or traumatic disruption, initial extension	avoid post service review.		
<u> </u>				

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
33884	Placement of proximal extension prosthesis for endovascular	MP Criteria: Procedure/service reviewed	1/1/2006	12/31/2999
	repair of descending thoracic aorta (eg, aneurysm,	against Medical Policy Criteria. Submit		
	pseudoaneurysm, dissection, penetrating ulcer, intramural	for Recommended Clinical Review to		
	hematoma, or traumatic disruption); each additional proximal	avoid post-service review.		
	extension (List separately in addition to code for primary			
	procedure)			<u> </u>
33927	Implantation of a total replacement heart system (artificial heart)		1/1/2018	12/31/2999
	with recipient cardiectomy	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
33928	Removal and replacement of total replacement heart system	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	(artificial heart)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
22020		han committee and a second	4 /4 /2040	4.2 /24 /2000
33929	, , , , , , , , , , , , , , , , , , , ,	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	heart transplantation (List separately in addition to code for primary procedure)	against Medical Policy Criteria. Submit for Recommended Clinical Review to		
	primary procedure)	avoid post-service review.		
		avoid post-service review.		
33975	Insertion of ventricular assist device; extracorporeal, single	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	ventricle	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
33976	Insertion of ventricular assist device; extracorporeal,	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	biventricular	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	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
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	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
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	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
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	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
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
36260	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	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
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	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
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	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
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	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
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	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
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	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
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (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).	12/1/2020	12/31/2999
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; 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

Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed	4 /4 /2005	
	Ivir Criteria. Procedure/service reviewed	1/1/2005	12/31/2999
inclusive of all imaging guidance and monitoring, percutaneous,	against Medical Policy Criteria. Submit		
radiofrequency; subsequent vein(s) treated in a single extremity,	for Recommended Clinical Review to		
each through separate access sites (List separately in addition to	avoid post-service review.		
code for primary procedure)			
Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
inclusive of all imaging guidance and monitoring, percutaneous,	against Medical Policy Criteria. Submit		
laser; first vein treated	for Recommended Clinical Review to		
	avoid post-service review.		
Endovenous ablation therapy of incompetent vein, extremity,	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
inclusive of all imaging guidance and monitoring, percutaneous,	against Medical Policy Criteria. Submit		
laser; subsequent vein(s) treated in a single extremity, each	for Recommended Clinical Review to		
through separate access sites (List separately in addition to code	avoid post-service review.		
for primary procedure)			
Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed	9/1/2019	12/31/2999
transcatheter delivery of a chemical adhesive (eg, cyanoacrylate)	against Medical Policy Criteria. Submit		
remote from the access site, inclusive of all imaging guidance and	for Recommended Clinical Review to		
monitoring, percutaneous; first vein treated	avoid post-service review.		
Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed	9/1/2019	12/31/2999
transcatheter delivery of a chemical adhesive (eg, cyanoacrylate)	against Medical Policy Criteria. Submit		
remote from the access site, inclusive of all imaging guidance and	for Recommended Clinical Review to		
monitoring, percutaneous; subsequent vein(s) treated in a single	avoid post-service review.		
extremity, each through separate access sites (List separately in			
addition to code for primary procedure)			
Therapeutic apheresis; for white blood cells	MP Criteria: Procedure/service reviewed	1/1/2003	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
_	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated  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)  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  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)	code for primary procedure)  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated  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)  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  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)  Therapeutic apheresis; for white blood cells  MP Criteria: Procedure/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 Revi	code for primary procedure)  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated  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)  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  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)  Therapeutic apheresis; for white blood cells  MP Criteria: Procedure/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.  Therapeutic apheresis; for white blood cells  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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	our Clinical Payment and Coding Policy	1/1/2023	1/14/2025
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	review. Check EIU policy, which is one of our Clinical Payment and Coding Policy	1/1/2023	1/14/2025
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
37217 37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.		12/31/2999
3/218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	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
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	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
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	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
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	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
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	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
37718	Ligation, division, and stripping, short saphenous vein	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
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	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
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	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
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (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
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	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
37788	Penile revascularization, artery, with or without vein graft	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
37790	Penile venous occlusive procedure	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
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	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
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	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
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	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
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	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
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	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
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	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
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	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
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	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
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	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
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
38225	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
38226	Chimeric antigen receptor T-cell ( CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
38227	Chimeric antigen receptor T-cell ( CAR-T) therapy; receipt and preparation of CAR-T cells for administration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
38228	Chimeric antigen receptor T-cell ( CAR-T) therapy; CAR-T cells for administration, autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
38232	Bone marrow harvesting for transplantation; autologous	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
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
38242	Allogeneic lymphocyte infusions	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
38243	Hematopoietic progenitor cell (HPC); HPC boost	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
38308	Lymphangiotomy or other operations on lymphatic channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2014	12/31/2999
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	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
42140	Uvulectomy, excision of uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2006	12/31/2999
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	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
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	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
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2016	12/31/2999
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	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
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes 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)	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
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2010	12/31/2999
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	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
43285	Removal of esophageal sphincter augmentation device	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
43289	Unlisted laparoscopy procedure, esophagus	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment 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).	1/1/2023	12/31/2999
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(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).	1/1/2023	12/31/2999
43632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	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
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and 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.	11/15/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band 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
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 Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43772	Laparoscopy, surgical, gastric restrictive procedure; removal 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
43773	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
43774	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
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
43847	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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
43886	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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).	9/1/2020	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
49412	(eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
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
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
51721	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement of an endorectal cooling device, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, 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
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	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
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	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
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	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
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (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.	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
53451	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed	10/1/2024	12/31/2999
	bilateral insertion, including cystourethroscopy and imaging	by the Plan. Not subject to pre-service		
	guidance	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
53452	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed	10/1/2024	12/31/2999
	unilateral insertion, including cystourethroscopy and imaging	by the Plan. Not subject to pre-service		
	guidance	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
53453	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed	10/1/2024	12/31/2999
	removal, each balloon	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
53454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
53855	Insertion of a temporary prostatic urethral stent, including	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	urethral measurement	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
53860	Transurethral radiofrequency micro-remodeling of the female	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	bladder neck and proximal urethra for stress urinary	by the Plan. Not subject to pre-service		
	incontinence	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
53865	Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
53866	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
54110	Excision of penile plaque (Peyronie disease);	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
54111	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	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
54112	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	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
54125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
54200	Injection procedure for Peyronie disease;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2010	12/31/2999
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2010	12/31/2999
54235	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	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
54240	Penile plethysmography	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
54360	Plastic operation on penis to correct angulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2016	12/31/2999
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
54401	Insertion of penile prosthesis; inflatable (self-contained)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	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
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	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
54410	Removal and replacement of all component(s) of a multi- component, inflatable penile prosthesis at the same operative session	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
54411	Removal and replacement of all components of a multi- component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	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
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	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
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	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
54440	Plastic operation of penis for injury	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999
54660	Insertion of testicular prosthesis (separate procedure)	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
55400	Vasovasostomy, vasovasorrhaphy	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
55870		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/1/2015	12/31/2999
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2007	12/31/2999
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
55970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
55980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
56805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	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
57291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
57292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	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
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	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
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
58321	Artificial insemination; intra-cervical	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
58322	Artificial insemination; intra-uterine	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.	1/1/1950	12/31/2999

Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Transcervical ablation of uterine fibroid(s), including	•	1/1/2024	12/31/2999
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radiofrequency	for Recommended Clinical Review to		
	avoid post-service review.		
Tubotubal anastomosis	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Tubouterine implantation	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Follicle puncture for oocyte retrieval, any method	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Embryo transfer, intrauterine	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Gamete, zygote, or embryo intrafallopian transfer, any method	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Fetal umbilical cord occlusion, including ultrasound guidance	MP Criteria: Procedure/service reviewed	10/1/2023	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Fetal fluid drainage (eg. vesicocentesis, thoracocentesis,	MP Criteria: Procedure/service reviewed	12/1/2022	12/31/2999
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	avoia post service review.		
	intraoperative ultrasound guidance and monitoring, radiofrequency  Tubotubal anastomosis  Tubouterine implantation  Follicle puncture for oocyte retrieval, any method  Embryo transfer, intrauterine  Gamete, zygote, or embryo intrafallopian transfer, any method	intraoperative ultrasound guidance and monitoring, radiofrequency  against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Tubotubal anastomosis  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Tubouterine implantation  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Follicle puncture for oocyte retrieval, any method  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Embryo transfer, intrauterine  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Gamete, zygote, or embryo intrafallopian transfer, any method  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Fetal umbilical cord occlusion, including ultrasound guidance  Fetal fluid drainage (eg, vesicocentesis, thoracocentesis,  MP Criteria: Procedure/service reviewed avoid post-service reviewed.	intraoperative ultrasound guidance and monitoring, radiofrequency  against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Tubotubal anastomosis  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Tubouterine implantation  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Follicle puncture for oocyte retrieval, any method  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Embryo transfer, intrauterine  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Mon Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Gamete, zygote, or embryo intrafallopian transfer, any method  Mon Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Fetal umbilical cord occlusion, including ultrasound guidance  Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance  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 reviewed to apainst Medical Policy Criteria. Submit for Recommended Clinical Review to against Medical Policy Criteria. Submit for Recommended Clinical Review to

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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
60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
60661	Ablation of 1 or more thyroid nodule(s), additional lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency (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.	1/1/2025	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target intracranial, including stereotactic navigation and frame placement, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
61783	Stereotactic computer-assisted (navigational) procedure; spinal (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).	7/1/2024	1/31/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
61889	Insertion of skull-mounted cranial neurostimulator pulse	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	generator or receiver, including craniectomy or craniotomy,	against Medical Policy Criteria. Submit		
	when performed, with direct or inductive coupling, with	for Recommended Clinical Review to		
	connection to depth and/or cortical strip electrode array(s)	avoid post-service review.		
61891	Revision or replacement of skull-mounted cranial	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	neurostimulator pulse generator or receiver with connection to	against Medical Policy Criteria. Submit		
	depth and/or cortical strip electrode array(s)	for Recommended Clinical Review to		
		avoid post-service review.		
61892	Removal of skull-mounted cranial neurostimulator pulse	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	generator or receiver with cranioplasty, when performed	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
62263	Percutaneous lysis of epidural adhesions using solution injection	EIU: Procedure/service not reimbursed	8/1/2022	12/31/2999
	(eg, hypertonic saline, enzyme) or mechanical means (eg,	by the Plan. Not subject to pre-service		
	catheter) including radiologic localization (includes contrast when	review. Check EIU policy, which is one of		
	administered), multiple adhesiolysis sessions; 2 or more days	our Clinical Payment and Coding Policy		
		(CPCP).		
62264	, , ,	·	8/1/2022	12/31/2999
	(eg, hypertonic saline, enzyme) or mechanical means (eg,	by the Plan. Not subject to pre-service		
	catheter) including radiologic localization (includes contrast when	• • •		
	administered), multiple adhesiolysis sessions; 1 day	our Clinical Payment and Coding Policy		
52252		(CPCP).	2/4/2025	42/24/2000
62268	Percutaneous aspiration, spinal cord cyst or syrinx	MP Criteria: Procedure/service reviewed	2/1/2025	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
62287		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
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (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.	2/1/2025	12/31/2999
64505	Injection, anesthetic agent; sphenopalatine ganglion	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
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	5/14/2025
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral 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).	5/15/2025	12/31/2999
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	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
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2022	12/31/2999
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	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
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (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
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, 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
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	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
64620	Destruction by neurolytic agent, intercostal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2023	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	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
64629	including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary	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
64640	Destruction by neurolytic agent; other peripheral nerve or branch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2021	12/31/2999
64650	Chemodenervation of eccrine glands; both axillae	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
64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	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
64802	Sympathectomy, cervical	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2015	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
64804	Sympathectomy, cervicothoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2015	12/31/2999
64809	Sympathectomy, thoracolumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2015	12/31/2999
64818	Sympathectomy, lumbar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2011	12/31/2999
64820	Sympathectomy; digital arteries, each digit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2015	12/31/2999
64823	Sympathectomy; superficial palmar arch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2015	12/31/2999
65710	Keratoplasty (corneal transplant); anterior lamellar	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2008	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2008	12/31/2999
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2008	12/31/2999
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2008	12/31/2999
65756	Keratoplasty (corneal transplant); endothelial	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
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (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.	1/1/2015	12/31/2999
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999
65765	Keratophakia	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
65767	Epikeratoplasty	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
65770	Keratoprosthesis	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
65771	Radial keratotomy	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999
65772	Corneal relaxing incision for correction of surgically induced astigmatism	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
65775	Corneal wedge resection for correction of surgically induced astigmatism	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
65778	Placement of amniotic membrane on the ocular surface; without sutures	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
65785	Implantation of intrastromal corneal ring segments	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	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
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	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
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	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
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	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
67027	Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	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
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2007	12/31/2999
67221	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)	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
67225	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)	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
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	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
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	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
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	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
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	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
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	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
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle- levator resection (eg, Fasanella-Servat type)	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
69090	Ear piercing	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
69300	Otoplasty, protruding ear, with or without size reduction	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
69676	Tympanic neurectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2011	12/31/2999
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
69719	Replacement (including removal of existing device),	MP Criteria: Procedure/service reviewed	12/15/2022	12/31/2999
	osseointegrated implant, skull; with magnetic transcutaneous	against Medical Policy Criteria. Submit		
	attachment to external speech processor, within the mastoid	for Recommended Clinical Review to		
	and/or involving a bony defect less than 100 sq mm surface area	avoid post-service review.		
	of bone deep to the outer cranial cortex			
69728	Removal, entire osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed	1/1/2023	12/31/2999
	transcutaneous attachment to external speech processor,	against Medical Policy Criteria. Submit		
	outside the mastoid and involving a bony defect greater than or	for Recommended Clinical Review to		
	equal to 100 sq mm surface area of bone deep to the outer	avoid post-service review.		
	cranial cortex			
69729	Implantation, osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed	1/1/2023	12/31/2999
	transcutaneous attachment to external speech processor,	against Medical Policy Criteria. Submit		
	outside of the mastoid and resulting in removal of greater than	for Recommended Clinical Review to		
	or equal to 100 sq mm surface area of bone deep to the outer	avoid post-service review.		
	cranial cortex			
69730	Replacement (including removal of existing device),	MP Criteria: Procedure/service reviewed	1/1/2023	12/31/2999
	osseointegrated implant, skull; with magnetic transcutaneous	against Medical Policy Criteria. Submit		
	attachment to external speech processor, outside the mastoid	for Recommended Clinical Review to		
	and involving a bony defect greater than or equal to 100 sq mm	avoid post-service review.		
	surface area of bone deep to the outer cranial cortex			
75580	Noninvasive estimate of coronary fractional flow reserve (FFR)	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	derived from augmentative software analysis of the data set	against Medical Policy Criteria. Submit		
	from a coronary computed tomography angiography, with	for Recommended Clinical Review to		
		avoid post-service review.		
	care professional			
75894	Transcatheter therapy, embolization, any method, radiological	MP Criteria: Procedure/service reviewed	2/1/2008	12/31/2999
	supervision and interpretation	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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	·		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
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	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
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
77499	Unlisted procedure, therapeutic radiology treatment management	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
77799	Unlisted procedure, clinical brachytherapy	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
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (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.	9/15/2020	12/31/2999
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	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
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	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
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2013	12/31/2999
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	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
81243	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	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
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	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
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (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.	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
81538	Oncology (lung), mass spectrometric 8-protein signature,	MP Criteria: Procedure/service reviewed	10/3/2016	12/31/2999
	including amyloid A, utilizing serum, prognostic and predictive	against Medical Policy Criteria. Submit		
	algorithm reported as good versus poor overall survival	for Recommended Clinical Review to		
		avoid post-service review.		
81599	Unlisted multianalyte assay with algorithmic analysis	MP Criteria: Procedure/service reviewed	10/3/2016	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
82523	Collagen cross links, any method	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
82777	Galectin-3	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
83695	Lipoprotein (a)	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
83701	Lipoprotein, blood; high resolution fractionation and quantitation	EIU: Procedure/service not reimbursed	1/15/2015	12/31/2999
	of lipoproteins including lipoprotein subclasses when performed	by the Plan. Not subject to pre-service		
	(eg, electrophoresis, ultracentrifugation)	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s)	EIU: Procedure/service not reimbursed	1/15/2015	12/31/2999
	(eg, by nuclear magnetic resonance spectroscopy), includes	by the Plan. Not subject to pre-service		
	lipoprotein particle subclass(es), when performed	review. Check EIU 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	1/1/2019	12/31/2999
		by the Plan. 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	12/15/2014	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	8/15/2015	12/31/2999
	protein(s) (eg, placental alpha microglobulin-1 [PAMG-1],	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
	specimen	our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
84431	Thromboxane metabolite(s), including thromboxane if	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	performed, urine	by the Plan. 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	10/3/2016	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
86001	Allergen specific IgG quantitative or semiquantitative, each	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
00001	allergen	by the Plan. Not subject to pre-service	12, 1, 2020	12,31,233
	4.10,80.1	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
86328	Immunoassay for infectious agent antibody(ies), qualitative or	EIU: Procedure/service not reimbursed	6/1/2023	12/31/2999
	semiquantitative, single-step method (eg, reagent strip); severe	by the Plan. Not subject to pre-service		
	acute respiratory syndrome coronavirus 2 (SARS-CoV-2)	review. Check EIU policy, which is one of		
	(coronavirus disease [COVID-19])	our Clinical Payment and Coding Policy		
		(CPCP).		
86343	Leukocyte histamine release test (LHR)	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
86352	Cellular function assay involving stimulation (eg, mitogen or	MP Criteria: Procedure/service reviewed	1/1/2012	12/31/2999
	antigen) and detection of biomarker (eg, ATP)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen	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
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer	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
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative	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
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	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
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
86950	Leukocyte transfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2020	12/31/2999
88375	Optical endomicroscopic image(s), interpretation and report, real- time or referred, each endoscopic session	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
89250	Culture of oocyte(s)/embryo(s), less than 4 days;	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
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
89253	Assisted embryo hatching, microtechniques (any method)	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
89254	Oocyte identification from follicular fluid	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89255	Preparation of embryo for transfer (any method)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89257	Sperm identification from aspiration (other than seminal fluid)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89258	Cryopreservation; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89259	Cryopreservation; sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89264	Sperm identification from testis tissue, fresh or cryopreserved	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89268	Insemination of oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2012	12/31/2999
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2012	12/31/2999
89325	Sperm antibodies	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89329	Sperm evaluation; hamster penetration test	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/1/2015	12/31/2999
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
89335	Cryopreservation, reproductive tissue, testicular	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89337	Cryopreservation, mature oocyte(s)	Non Covered: Procedure/service not	1/1/2019	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89342	Storage (per year); embryo(s)	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89343	Storage (per year); sperm/semen	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89344	Storage (per year); reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89346	Storage (per year); oocyte(s)	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89352	Thawing of cryopreserved; embryo(s)	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89353	Thawing of cryopreserved; sperm/semen, each aliquot	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
89356	Thawing of cryopreserved; oocytes, each aliquot	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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 preservice review.	7/1/2022	12/31/2999
90593	Chikungunya virus vaccine, recombinant, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2025	2/13/2025
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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
90666	Influenza virus vaccine (IIV), 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 (IIV), 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 preservice 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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	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
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (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.	4/1/2021	12/31/2999
91034	electrode(s) placement, recording, analysis and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
91065	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or orocecal gastrointestinal transit)	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
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus 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).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
91112	Gastrointestinal transit and pressure measurement, stomach	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	through colon, wireless capsule, with interpretation and report	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	endoscopy), colon, with interpretation and report	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
91117	Colon motility (manometric) study, minimum 6 hours continuous		12/1/2020	12/31/2999
	recording (including provocation tests, eg, meal, intracolonic	against Medical Policy Criteria. Submit		
	balloon distension, pharmacologic agents, if performed), with	for Recommended Clinical Review to		
	interpretation and report	avoid post-service review.		
91132	Electrogastrography, diagnostic, transcutaneous;	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	provocative testing	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
92065	Orthoptic training; performed by a physician or other qualified	MP Criteria: Procedure/service reviewed	1/1/2019	12/31/2999
	health care professional	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
92066	Orthoptic training; under supervision of 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.	1/1/2023	12/31/2999
92132	Scanning computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with 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).	9/1/2020	12/31/2999
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, 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).	12/1/2020	12/31/2999
92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)	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
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	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
92512	Nasal function studies (eg, rhinomanometry)	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
92517	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	interpretation and report; cervical (cVEMP)	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
92518	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	interpretation and report; ocular (oVEMP)	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
92519	Vestibular evoked myogenic potential (VEMP) testing, with	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	interpretation and report; cervical (cVEMP) and ocular (oVEMP)	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic	MP Criteria: Procedure/service reviewed	6/5/2018	12/31/2999
	testing)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
92548	Computerized dynamic posturography sensory organization test	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	(CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway,	by the Plan. Not subject to pre-service		
	platform sway, eyes closed platform sway, platform and visual	review. Check EIU policy, which is one of		
	sway), including interpretation and report;	our Clinical Payment and Coding Policy		
		(CPCP).		
92549	Computerized dynamic posturography sensory organization test	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	(CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway,	by the Plan. Not subject to pre-service		
	platform sway, eyes closed platform sway, platform and visual	review. Check EIU policy, which is one of		
	sway), including interpretation and report; with motor control	our Clinical Payment and Coding Policy		
	test (MCT) and adaptation test (ADT)	(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
92979	Endoluminal imaging of coronary vessel or graft using	MP Criteria: Procedure/service reviewed	6/5/2018	12/31/2999
	intravascular ultrasound (IVUS) or optical coherence tomography	against Medical Policy Criteria. Submit		
	(OCT) during diagnostic evaluation and/or therapeutic	for Recommended Clinical Review to		
	intervention including imaging supervision, interpretation and	avoid post-service review.		
	report; each additional vessel (List separately in addition to code			
	for primary procedure)			
93025	Microvolt T-wave alternans for assessment of ventricular	MP Criteria: Procedure/service reviewed	11/15/2014	12/31/2999
	arrhythmias	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
93050	Arterial pressure waveform analysis for assessment of central	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	arterial pressures, includes obtaining waveform(s), digitization	by the Plan. Not subject to pre-service		
	and application of nonlinear mathematical transformations to	review. Check EIU policy, which is one of		
	determine central arterial pressures and augmentation index,	our Clinical Payment and Coding Policy		
	with interpretation and report, upper extremity artery, non-	(CPCP).		
	invasive			
93150	Therapy activation of implanted phrenic nerve stimulator system,		5/15/2024	12/31/2999
	including all interrogation and programming	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
00151		(CPCP).	= /+ = /0.00 +	10/01/0000
93151	Interrogation and programming (minimum one parameter) of	The state of the s	5/15/2024	12/31/2999
	implanted phrenic nerve stimulator system	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
93152	Interrogation and programming of implanted phrenic nerve	(CPCP).  EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
33132	stimulator system during polysomnography	by the Plan. Not subject to pre-service	3/13/2024	12/31/2999
	Stillidiator system during porysonning raphry	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
93153	Interrogation without programming of implanted phrenic nerve stimulator 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
93228	External mobile cardiovascular telemetry with electrocardiographic recording, 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 for up to 30 days; review and interpretation with 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.	9/1/2020	12/31/2999
93229	External mobile cardiovascular telemetry with electrocardiographic recording, 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 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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) 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.	9/1/2020	12/31/2999
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2022	12/31/2999
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2007	12/31/2999
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	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
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2008	12/31/2999
93701	Bioimpedance-derived physiologic cardiovascular analysis	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
93702		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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
93740	Temperature gradient studies	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
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	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
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	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
93886	Transcranial Doppler study of the intracranial arteries; complete study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
93888	Transcranial Doppler study of the intracranial arteries; limited study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
93893	Transcranial Doppler study of the intracranial arteries; venous-	MP Criteria: Procedure/service reviewed	1/1/2009	12/31/2999
	arterial shunt detection with intravenous microbubble injection	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
94014	Patient-initiated spirometric recording per 30-day period of time;	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	includes reinforced education, transmission of spirometric	by the Plan. Not subject to pre-service		
	tracing, data capture, analysis of transmitted data, periodic	review. Check EIU policy, which is one of		
	recalibration and review and interpretation by a physician or	our Clinical Payment and Coding Policy		
	other qualified health care professional	(CPCP).		
94015	Patient-initiated spirometric recording per 30-day period of time;	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	recording (includes hook-up, reinforced education, data	by the Plan. Not subject to pre-service		
	transmission, data capture, trend analysis, and periodic	review. Check EIU policy, which is one of		
	recalibration)	our Clinical Payment and Coding Policy		
		(CPCP).		
94016	Patient-initiated spirometric recording per 30-day period of time;	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	review and interpretation only by a physician or other qualified	by the Plan. Not subject to pre-service		
	health care professional	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
94669	Mechanical chest wall oscillation to facilitate lung function, per	MP Criteria: Procedure/service reviewed	1/1/2014	12/31/2999
	session	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
94774	Pediatric home apnea monitoring event recording including	MP Criteria: Procedure/service reviewed	1/1/2007	12/31/2999
	respiratory rate, pattern and heart rate per 30-day period of	against Medical Policy Criteria. Submit		
	time; includes monitor attachment, download of data, review,	for Recommended Clinical Review to		
	interpretation, and preparation of a report by a physician or	avoid post-service review.		
	other qualified health care professional			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
94775	Pediatric home apnea monitoring event recording including	MP Criteria: Procedure/service reviewed	1/1/2007	12/31/2999
	respiratory rate, pattern and heart rate per 30-day period of	against Medical Policy Criteria. Submit		
	time; monitor attachment only (includes hook-up, initiation of	for Recommended Clinical Review to		
	recording and disconnection)	avoid post-service review.		
94776	Pediatric home apnea monitoring event recording including	MP Criteria: Procedure/service reviewed	1/1/2007	12/31/2999
	respiratory rate, pattern and heart rate per 30-day period of	against Medical Policy Criteria. Submit		
	time; monitoring, download of information, receipt of	for Recommended Clinical Review to		
	transmission(s) and analyses by computer only	avoid post-service review.		
94777	Pediatric home apnea monitoring event recording including	MP Criteria: Procedure/service reviewed	1/1/2007	12/31/2999
	respiratory rate, pattern and heart rate per 30-day period of	against Medical Policy Criteria. Submit		
	time; review, interpretation and preparation of report only by a	for Recommended Clinical Review to		
	physician or other qualified health care professional	avoid post-service review.		
95060	Ophthalmic mucous membrane tests	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
95065	Direct nasal mucous membrane test	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
95700	Electroencephalogram (EEG) continuous recording, with video	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	when performed, setup, patient education, and takedown when	against Medical Policy Criteria. Submit		
	performed, administered in person by EEG technologist,	for Recommended Clinical Review to		
	minimum of 8 channels	avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
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 description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	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
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	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
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 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
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	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
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
95711	Electroencephalogram with video (VEEG), 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
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	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
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	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
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 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
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	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
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	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

	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
events, analysis of spike and seizure detection, interpretation	for Recommended Clinical Review to		
and report, 2-12 hours of EEG recording; without video	avoid post-service review.		
Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
events, analysis of spike and seizure detection, interpretation	for Recommended Clinical Review to		
and report, 2-12 hours of EEG recording; with video (VEEG)	avoid post-service review.		
Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
events, analysis of spike and seizure detection, each increment of	for Recommended Clinical Review to		
greater than 12 hours, up to 26 hours of EEG recording,	avoid post-service review.		
interpretation and report after each 24-hour period; without			
video			
Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
events, analysis of spike and seizure detection, each increment of	for Recommended Clinical Review to		
greater than 12 hours, up to 26 hours of EEG recording,	avoid post-service review.		
interpretation and report after each 24-hour period; with video (VEEG)			
Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
and summary report, complete study; greater than 36 hours, up	avoid post-service review.		
to 60 hours of EEG recording, without video			
	other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and 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 (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up	other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and 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 (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up	other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and 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 (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and 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 (VEEG)  Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up avoid post-service review.

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
95722	Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
	events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
	and summary report, complete study; greater than 36 hours, up	avoid post-service review.		
	to 60 hours of EEG recording, with video (VEEG)			
95723	Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
	events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
	and summary report, complete study; greater than 60 hours, up	avoid post-service review.		
	to 84 hours of EEG recording, without video			
95724	Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
	events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
	and summary report, complete study; greater than 60 hours, up	avoid post-service review.		
	to 84 hours of EEG recording, with video (VEEG)			
95725	Electroencephalogram (EEG), continuous recording, physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
	events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
	and summary report, complete study; greater than 84 hours of	avoid post-service review.		
	EEG recording, without video			
95726	, , ,	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional review of recorded	against Medical Policy Criteria. Submit		
	events, analysis of spike and seizure detection, interpretation,	for Recommended Clinical Review to		
	and summary report, complete study; greater than 84 hours of	avoid post-service review.		
	EEG recording, with video (VEEG)			
95782		MP Criteria: Procedure/service reviewed	7/15/2022	12/31/2999
	more additional parameters of sleep, attended by a technologist	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2022	12/31/2999
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	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
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
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 Clinical Review to avoid post-service review.	2/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
95811	Polysomnography; age 6 years or older, sleep staging with 4 or	MP Criteria: Procedure/service reviewed	2/15/2022	12/31/2999
	more additional parameters of sleep, with initiation of	against Medical Policy Criteria. Submit		
	continuous positive airway pressure therapy or bilevel	for Recommended Clinical Review to		
	ventilation, attended by a technologist	avoid post-service review.		
95905	Motor and/or sensory nerve conduction, using preconfigured	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	electrode array(s), amplitude and latency/velocity study, each	by the Plan. Not subject to pre-service		
	limb, includes F-wave study when performed, with interpretation	review. Check EIU policy, which is one of		
	and report	our Clinical Payment and Coding Policy		
		(CPCP).		
95919	Quantitative pupillometry with physician or other qualified	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	health care professional interpretation and report, unilateral or	by the Plan. Not subject to pre-service		
	bilateral	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
95954	Pharmacological or physical activation requiring physician or	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	other qualified health care professional attendance during EEG	against Medical Policy Criteria. Submit		
	recording of activation phase (eg, thiopental activation test)	for Recommended Clinical Review to		
		avoid post-service review.		
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	spike analysis)	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
95961	Functional cortical and subcortical mapping by stimulation	MP Criteria: Procedure/service reviewed	8/1/2015	12/31/2999
	and/or recording of electrodes on brain surface, or of depth	against Medical Policy Criteria. Submit		
	electrodes, to provoke seizures or identify vital brain structures;	for Recommended Clinical Review to		
	initial hour of attendance by a physician or other qualified health	avoid post-service review.		
	care professional			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
95962	Functional cortical and subcortical mapping by stimulation	MP Criteria: Procedure/service reviewed	8/1/2015	12/31/2999
	and/or recording of electrodes on brain surface, or of depth	against Medical Policy Criteria. Submit		
	electrodes, to provoke seizures or identify vital brain structures;	for Recommended Clinical Review to		
	each additional hour of attendance by a physician or other	avoid post-service review.		
	qualified health care professional (List separately in addition to			
	code for primary procedure)			
95965	Magnetoencephalography (MEG), recording and analysis; for	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	spontaneous brain magnetic activity (eg, epileptic cerebral cortex	against Medical Policy Criteria. Submit		
	localization)	for Recommended Clinical Review to		
		avoid post-service review.		
95966	Magnetoencephalography (MEG), recording and analysis; for	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	evoked magnetic fields, single modality (eg, sensory, motor,	against Medical Policy Criteria. Submit		
	language, or visual cortex localization)	for Recommended Clinical Review to		
		avoid post-service review.		
95967	Magnetoencephalography (MEG), recording and analysis; for	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	evoked magnetic fields, each additional modality (eg, sensory,	against Medical Policy Criteria. Submit		
	motor, language, or visual cortex localization) (List separately in	for Recommended Clinical Review to		
	addition to code for primary procedure)	avoid post-service review.		
96000	Comprehensive computer-based motion analysis by video-taping	MP Criteria: Procedure/service reviewed	7/15/2010	12/31/2999
	and 3D kinematics;	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
96001	Comprehensive computer-based motion analysis by video-taping	MP Criteria: Procedure/service reviewed	7/15/2010	12/31/2999
	and 3D kinematics; with dynamic plantar pressure measurements	against Medical Policy Criteria. Submit		
	during walking	for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 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
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 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
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	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
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
96571	Photodynamic therapy by endoscopic application of light to	MP Criteria: Procedure/service reviewed	9/15/2008	12/31/2999
	ablate abnormal tissue via activation of photosensitive drug(s);	against Medical Policy Criteria. Submit		
	each additional 15 minutes (List separately in addition to code	for Recommended Clinical Review to		
	for endoscopy or bronchoscopy procedures of lung and	avoid post-service review.		
	gastrointestinal tract)			
96573	Photodynamic therapy by external application of light to destroy	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	premalignant lesions of the skin and adjacent mucosa with	against Medical Policy Criteria. Submit		
	application and illumination/activation of photosensitizing	for Recommended Clinical Review to		
	drug(s) provided by a physician or other qualified health care	avoid post-service review.		
	professional, per day			
96574	Debridement of premalignant hyperkeratotic lesion(s) (ie,	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	targeted curettage, abrasion) followed with photodynamic	against Medical Policy Criteria. Submit		
	therapy by external application of light to destroy premalignant	for Recommended Clinical Review to		
	lesions of the skin and adjacent mucosa with application and	avoid post-service review.		
	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	8/15/2009	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe	MP Criteria: Procedure/service reviewed	7/1/2010	12/31/2999
	photoresponsive dermatoses requiring at least 4-8 hours of care	against Medical Policy Criteria. Submit		
	under direct supervision of the physician (includes application of	for Recommended Clinical Review to		
	medication and dressings)	avoid post-service review.		
96922	Excimer laser treatment for psoriasis; over 500 sq cm	MP Criteria: Procedure/service reviewed	10/15/2007	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
96931	Reflectance confocal microscopy (RCM) for cellular and sub- cellular imaging of skin; image acquisition and interpretation and report, first lesion	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
96932	Reflectance confocal microscopy (RCM) for cellular and sub- cellular imaging of skin; image acquisition only, first lesion	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
96933	Reflectance confocal microscopy (RCM) for cellular and sub- cellular imaging of skin; interpretation and report only, first lesion	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
96934		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
96935	Reflectance confocal microscopy (RCM) for cellular and sub- cellular imaging of skin; image acquisition only, each additional lesion (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.	9/1/2020	12/31/2999
96936	Reflectance confocal microscopy (RCM) for cellular and sub- cellular imaging of skin; interpretation and report only, each additional lesion (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.	9/1/2020	12/31/2999
97012	Application of a modality to 1 or more areas; traction, mechanical	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
97014		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/14/2012	12/31/2999
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	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
97032		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/14/2012	12/31/2999
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	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
97124	massage, including effleurage, petrissage and/or tapotement	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2016	12/31/2999
97169	components: A history and physical activity profile with no		1/1/2017	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect 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.	Non Covered: Procedure/service not	Effective Date 1/1/2017	Ending Date 12/31/2999
97171	Athletic training evaluation, high complexity, requiring these	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2017	12/31/2999
97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there 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.	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2017	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	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
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999
97545	Work hardening/conditioning; initial 2 hours	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
97546	Work hardening/conditioning; each additional 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.	9/1/2020	12/31/2999
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	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
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage	MP Criteria: Procedure/service reviewed	1/1/2015	12/31/2999
	collection), utilizing disposable, non-durable medical equipment	against Medical Policy Criteria. Submit		
	including provision of exudate management collection system,	for Recommended Clinical Review to		
	topical application(s), wound assessment, and instructions for	avoid post-service review.		
	ongoing care, per session; total wound(s) surface area less than			
	or equal to 50 square centimeters			
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage	MP Criteria: Procedure/service reviewed	1/1/2015	12/31/2999
	collection), utilizing disposable, non-durable medical equipment	against Medical Policy Criteria. Submit		
	including provision of exudate management collection system,	for Recommended Clinical Review to		
	topical application(s), wound assessment, and instructions for	avoid post-service review.		
	ongoing care, per session; total wound(s) surface area greater			
	than 50 square centimeters			
97610	Low frequency, non-contact, non-thermal ultrasound, including	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
	topical application(s), when performed, wound assessment, and	by the Plan. Not subject to pre-service		
	instruction(s) for ongoing care, per day	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
97810	Acupuncture, 1 or more needles; without electrical stimulation,	Non Covered: Procedure/service not	3/15/2013	12/31/2999
	initial 15 minutes of personal one-on-one contact with the	covered by the Plan. Not subject to pre-		
	l'	service review.		
97811		Non Covered: Procedure/service not	3/15/2013	12/31/2999
	·	covered by the Plan. Not subject to pre-		
	the patient, with insertion of needle(s) (List separately in addition	service review.		
	to code for primary procedure)			
97813		Non Covered: Procedure/service not	3/15/2013	12/31/2999
	·	covered by the Plan. Not subject to pre-		
	Professional Control of the Control	service review.		
97814	Acupuncture, 1 or more needles; with electrical stimulation, each		3/15/2013	12/31/2999
	·	covered by the Plan. Not subject to pre-		
		service review.		
	code for primary procedure)			

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
98962	Education and training for patient self-management by a	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	nonphysician qualified, health care professional using a	covered by the Plan. Not subject to pre-		
	standardized curriculum, face-to face with the patient (could	service review.		
	include caregiver/family) each 30 minutes; 5-8 patients			
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
99071	Educational supplies, such as books, tapes, and pamphlets, for	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	the patient's education at cost to physician or other qualified	covered by the Plan. Not subject to pre-		
	health care professional	service review.		
99075	Medical testimony	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
99080	Special reports such as insurance forms, more than the	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	information conveyed in the usual medical communications or	covered by the Plan. Not subject to pre-		
	standard reporting form	service review.		
99082	Unusual travel (eg, transportation and escort of patient)	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
99360	Standby service, requiring prolonged attendance, each 30	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	minutes (eg, operative standby, standby for frozen section, for	covered by the Plan. Not subject to pre-		
	cesarean/high risk delivery, for monitoring EEG)	service review.		
99450	Basic life and/or disability examination that includes:	Non Covered: Procedure/service not	1/1/2007	12/31/2999
	Measurement of height, weight, and blood pressure; Completion			
	of a medical history following a life insurance pro forma;	service review.		
	Collection of blood sample and/or urinalysis complying with			
	chain of custody protocols; and Completion of necessary			
	documentation/certificates.			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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 preservice 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 preservice 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
A0021	Ambulance service, outside state per mile, transport (medicaid only)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A0080	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A0090	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A0100	Non-emergency transportation; taxi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	1/1/1950	12/31/2999
		service review.		
A0110	Non-emergency transportation and bus, intra or inter state	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	carrier	covered by the Plan. Not subject to pre-		
		service review.		
A0120	Non-emergency transportation: mini-bus, mountain area	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	transports, or other transportation systems	covered by the Plan. Not subject to pre-		
		service review.		
A0130	Non-emergency transportation: wheel-chair van	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
A0140	Non-emergency transportation and air travel (private or	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	commercial) intra or inter state	covered by the Plan. Not subject to pre-		
		service review.		
A0160	Non-emergency transportation: per mile - case worker or social	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	worker	covered by the Plan. Not subject to pre-		
		service review.		
A0170	Transportation ancillary: parking fees, tolls, other	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.	1 /1 /1050	10/01/0000
A0180	Non-emergency transportation: ancillary: lodging-recipient	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
A0190	New concerns the management tiens are illens and a color recipions.	service review.  Non Covered: Procedure/service not	1 /1 /2021	12/21/2000
A0190	Non-emergency transportation: ancillary: meals-recipient	covered by the Plan. Not subject to pre-	1/1/2021	12/31/2999
		service review.		
A0200	Non-emergency transportation: ancillary: lodging escort	Non Covered: Procedure/service not	1/1/1950	12/31/2999
A0200	inon-emergency transportation, ancinary, loughing escort	covered by the Plan. Not subject to pre-	1, 1, 1930	12/31/2999
		service review.		
A0210	Non-emergency transportation: ancillary: meals-escort	Non Covered: Procedure/service not	5/3/2006	12/31/2999
7.0210	Tron emergency transportation, unclinary. Incais escort	covered by the Plan. Not subject to pre-	3/3/2000	12,31,233
		service review.		
		SCI VICE I CVICVV.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A0420	Ambulance waiting time (als or bls), one half (1/2) hour increments	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0432	Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/2/2007	12/31/2999
A0435	Fixed wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0888	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A0998	AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT	MP Criteria: Procedure/service reviewed	12/1/2016	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. 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	4/1/2022	12/31/2999
		by the Plan. 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	4/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed	4/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2023	12/31/2999
		by the Plan. 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	4/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed	10/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed	10/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
A2024	Resolve matrix or xenopatch, per square centimeter	EIU: Procedure/service not reimbursed	10/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A2025	Miro3d, per cubic 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).	10/1/2023	12/31/2999
A2026	Restrata minimatrix, 5 mg	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).	4/1/2024	12/31/2999
A2027	Matriderm, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
A2027	Matriderm, 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).	5/15/2025	12/31/2999
A2028	Micromatrix flex, per mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
A2028	Micromatrix flex, per mg	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).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
A2029	Mirotract wound matrix sheet, per cubic centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
A2029	Mirotract wound matrix sheet, per cubic 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).	5/15/2025	12/31/2999
A4100	Skin substitute, fda cleared as a device, not otherwise specified	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
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4342	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4438	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each	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
A4457	Enema tube, with or without adapter, any type, replacement only, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A4458	Enema bag with tubing, reusable	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A4468	Exsufflation belt, includes all supplies and accessories	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
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	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
A4541	Monthly supplies for use of device coded at e0733	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
A4542	Supplies and accessories for 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
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, 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).	5/15/2025	12/31/2999
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month	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
A4553	Non-disposable underpads, all sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2017	12/31/2999
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	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
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement 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).	1/15/2024	12/31/2999
A4575	Topical hyperbaric oxygen chamber, disposable	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
A4595	Electrical stimulator supplies, 2 lead, per month, (e. G. Tens, nmes)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/25/2013	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories, 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).	4/1/2023	12/31/2999
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
A4630	REPLACEMENT BATTERIES, MEDICALLY NECESSARY, TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/15/2007	12/31/2999
A4638	Replacement battery for patient-owned ear pulse generator, 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
A4639	Replacement pad for infrared heating pad system, 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).	12/15/2014	12/31/2999
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A4663	Blood pressure cuff only	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A4930	Gloves, sterile, per pair	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A4931	Oral thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A4932	Rectal thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A6000	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card	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
A6550	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	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
A6590	External urinary catheters; disposable, with wicking material, for use with suction pump, per month	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2023	12/31/2999
A6591	External urinary catheter; non-disposable, for use with suction pump, per month	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2023	12/31/2999
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	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
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	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).	5/15/2025	12/31/2999
A7025	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	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
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	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
A7047	Oral interface used with respiratory suction pump, each	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
A7049	Expiratory positive airway pressure intranasal resistance valve	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
A9150	Non-prescription drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A9152	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A9153	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	covered by the Plan. Not subject to pre-		
		service review.		
A9180	PEDICULOSIS (LICE INFESTATION) TREATMENT, TOPICAL, FOR	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	ADMINISTRATION BY PATIENT/CARETAKER	covered by the Plan. Not subject to pre-		
		service review.		
A9268	Programmer for transient, orally ingested capsule	MP Criteria: Procedure/service reviewed	5/15/2025	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
A9269	Programable, transient, orally ingested capsule, for use with	MP Criteria: Procedure/service reviewed	5/15/2025	12/31/2999
	external programmer, per month	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
A9270	Non-covered item or service	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
A9272	Wound suction, disposable, includes dressing, all accessories and	MP Criteria: Procedure/service reviewed	11/1/2013	12/31/2999
	components, any type, each	against 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,	Non Covered: Procedure/service not	1/1/2021	12/31/2999
	any type	covered by the Plan. Not subject to pre-		
		service review.		
A9281	REACHING/GRABBING DEVICE, ANY TYPE, ANY LENGTH, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A9285	Inversion/eversion correction device	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
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	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
A9300	Exercise equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries	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
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES	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
A9582	IODINE I-123 IOBENGUANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2013	12/31/2999
A9588	Fluciclovine f-18, diagnostic, 1 millicurie	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
A9596	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
A9602	Fluorodopa f-18, diagnostic, per millicurie	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
A9608	Flotufolastat f 18, diagnostic, 1 millicurie	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
A9609	Fludeoxyglucose f18 up to 15 millicuries	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
A9800	Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie	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 ML = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	covered by the Plan. Not subject to pre-		
		service review.		
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	Non Covered: Procedure/service not	1/1/2005	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
B4105	In-line cartridge containing digestive enzyme(s) for enteral	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
	feeding, each	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS,	covered by the Plan. Not subject to pre-		
	CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE	service review.		
	FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE,			
	100 CALORIES = 1 UNIT			
B4150	Enteral formula, nutritionally complete with intact nutrients,	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	includes proteins, fats, carbohydrates, vitamins and minerals,	covered by the Plan. Not subject to pre-		
	may include fiber, administered through an enteral feeding tube,	service review.		
	100 calories = 1 unit			
B4152	Enteral formula, nutritionally complete, calorically dense (equal	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	to or greater than 1. 5 kcal/ml) with intact nutrients, includes	covered by the Plan. Not subject to pre-		
	proteins, fats, carbohydrates, vitamins and minerals, may include	service review.		
	fiber, administered through an enteral feeding tube, 100 calories			
	= 1 unit			
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins	MP Criteria: Procedure/service reviewed	1/1/1950	12/31/2999
	(amino acids and peptide chain), includes fats, carbohydrates,	against Medical Policy Criteria. Submit		
	vitamins and minerals, may include fiber, administered through	for Recommended Clinical Review to		
	an enteral feeding tube, 100 calories = 1 unit	avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
B4154	Enteral formula, nutritionally complete, for special metabolic	MP Criteria: Procedure/service reviewed	1/1/1950	12/31/2999
	needs, excludes inherited disease of metabolism, includes	against Medical Policy Criteria. Submit		
	altered composition of proteins, fats, carbohydrates, vitamins	for Recommended Clinical Review to		
	and/or minerals, may include fiber, administered through an	avoid post-service review.		
	enteral feeding tube, 100 calories = 1 unit			
B4155	Enteral formula, nutritionally incomplete/modular nutrients,	MP Criteria: Procedure/service reviewed	1/1/1950	12/31/2999
	includes specific nutrients, carbohydrates (e. G. Glucose	against Medical Policy Criteria. Submit		
	polymers), proteins/amino acids (e. G. Glutamine, arginine), fat	for Recommended Clinical Review to		
	(e. G. Medium chain triglycerides) or combination, administered	avoid post-service review.		
	through an enteral feeding tube, 100 calories = 1 unit			
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM,	against Medical Policy Criteria. Submit		
	INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND	for Recommended Clinical Review to		
	MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN	avoid post-service review.		
	ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT			
B4158	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS,	against Medical Policy Criteria. Submit		
	CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE	for Recommended Clinical Review to		
	FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL	avoid post-service review.		
	FEEDING TUBE, 100 CALORIES = 1 UNIT			
B4159	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES	against Medical Policy Criteria. Submit		
	PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS,	for Recommended Clinical Review to		
	MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH	avoid post-service review.		
	AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN	against Medical Policy Criteria. Submit		
	0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS,	for Recommended Clinical Review to		
	FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY	avoid post-service review.		
	INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING			
	TUBE, 100 CALORIES = 1 UNIT			
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS,	against Medical Policy Criteria. Submit		
	CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE	for Recommended Clinical Review to		
	FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE,	avoid post-service review.		
	100 CALORIES = 1 UNIT			
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC	MP Criteria: Procedure/service reviewed	1/1/2005	12/31/2999
	NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES	against Medical Policy Criteria. Submit		
	PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS,	for Recommended Clinical Review to		
	MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL	avoid post-service review.		
	FEEDING TUBE, 100 CALORIES = 1 UNIT			
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	less (500 ml = 1 unit) - homemix	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
B4168	Parenteral nutrition solution; amino acid, 3. 5%, (500 ml = 1 unit)		7/27/2009	12/31/2999
	homemix	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
B4172	Parenteral nutrition solution; amino acid, 5. 5% through 7%, (500	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	ml = 1 unit) - homemix	against Medical Policy Criteria. Submit	' '	
	, in the second of the second	for Recommended Clinical Review to		
		avoid post-service review.		
		'		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
B4176	Parenteral nutrition solution; amino acid, 7% through 8. 5%, (500 ml = 1 unit) - homemix	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
B4178	Parenteral nutrition solution: amino acid, greater than 8. 5% (500 ml = 1 unit) - homemix	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
B4180	than 50% (500 ml=1 unit) - homemix	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
B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	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
B4193	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix	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
B4197	•	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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
B4199	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix	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
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) homemix per day	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
B4220	Parenteral nutrition supply kit; premix, per day	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
B4222	Parenteral nutrition supply kit; home mix, per day	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
B4224	Parenteral nutrition administration kit, per day	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
B5000	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix	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

Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Parenteral nutrition solution compounded amino acid and	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
carbohydrates with electrolytes, trace elements, and vitamins,	against Medical Policy Criteria. Submit		
including preparation, any strength, hepatic, hepatamine-premix	for Recommended Clinical Review to		
	avoid post-service review.		
Parenteral nutrition solution compounded amino acid and	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
carbohydrates with electrolytes, trace elements, and vitamins,	against Medical Policy Criteria. Submit		
including preparation, any strength, stress-branch chain amino	for Recommended Clinical Review to		
acids-freamine-hbc-premix	avoid post-service review.		
Parenteral nutrition infusion pump, portable	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Parenteral nutrition infusion pump, stationary	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	by the Plan. Not subject to pre-service		
	review. Check EIU policy, which is one of		
	our Clinical Payment and Coding Policy		
	(CPCP).		
	·	4/1/2021	12/31/2999
metal, polymer)			
	avoid post-service review.		
	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix  Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, stationary	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix for Recommended Clinical Review to avoid post-service review.  Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, stationary  Parenteral nutrition infusion pump, portable  Bull: 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).  Intravertebral body fracture augmentation with implant (e.g., MP Criteria: Procedure/service reviewed	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix including preparation, any strength, hepatic, hepatamine-premix including preparation, any strength, hepatic, hepatamine-premix including preparation, any strength, stress-branch chain amino acids and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, portable  Parenteral nutrition infusion pump, stationary  Parenteral nutrition infu

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	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
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	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
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
C1761	Catheter, transluminal intravascular lithotripsy, coronary	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
C1764	Event recorder, cardiac (implantable)	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
C1767	Generator, neurostimulator (implantable), non-rechargeable	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
C1778	Lead, neurostimulator (implantable)	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
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1787	Patient programmer, neurostimulator	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
C1816	Receiver and/or transmitter, neurostimulator (implantable)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
C1817	Septal defect implant system, intracardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2014	12/31/2999
C1818	Integrated keratoprosthesis	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
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	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
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
C1824	Generator, cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	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
C1827	with implantable stimulation lead and external paired stimulation controller	·	9/1/2023	12/31/2999
C1832	and all system components	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
C2614	Probe, percutaneous lumbar discectomy	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
C2616	Brachytherapy source, non-stranded, yttrium-90, per source	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	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
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (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.	4/1/2023	12/31/2999
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	,	4/1/2023	12/31/2999
C5274	Application of low cost skin substitute graft to trunk, arms, legs, 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 infants and children, or part thereof (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.	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
C5275	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 up to 100 sq cm; first 25 sq cm or less wound surface area	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
C5276	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 up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (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.	4/1/2023	12/31/2999
C5277	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; first 100 sq cm wound surface area, or 1% of body area of infants and children	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
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 infants and children, or part thereof (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.	4/1/2023	12/31/2999
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
C8003	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9173	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas),	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	per square centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9356	Tendon, porous matrix of cross-linked collagen and	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet),	by the Plan. Not subject to pre-service		
	per square centimeter	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9360	Dermal substitute, native, non-denatured collagen, neonatal	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	bovine origin (SurgiMend Collagen Matrix), per 0.5 square	by the Plan. Not subject to pre-service		
	centimeters	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	square centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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		The state of the s	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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 intravascular lithotripsy and atherectomy, 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
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, 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
C9768	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (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).	3/1/2021	12/31/2999
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	· ·	8/15/2021	12/31/2999
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), 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).	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
C9774	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	by the Plan. Not subject to pre-service		
	atherectomy, includes angioplasty within the same vessel (s),	review. Check EIU policy, which is one of		
	when performed	our Clinical Payment and Coding Policy		
		(CPCP).		
C9775	Revascularization, endovascular, open or percutaneous,	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	tibial/peroneal artery(ies); with intravascular lithotripsy and	by the Plan. Not subject to pre-service		
	transluminal stent placement(s), and atherectomy, includes	review. Check EIU policy, which is one of		
	angioplasty within the same vessel (s), when performed	our Clinical Payment and Coding Policy		
		(CPCP).		
C9777	Esophageal mucosal integrity testing by electrical impedance,	EIU: Procedure/service not reimbursed	8/15/2021	12/31/2999
	transoral, includes esophagoscopy or	by the Plan. Not subject to pre-service		
	esophagogastroduodenoscopy	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9780	Insertion of central venous catheter through central venous	MP Criteria: Procedure/service reviewed	10/1/2021	12/31/2999
	occlusion via inferior and superior approaches (e.g., inside-out	against Medical Policy Criteria. Submit		
	technique), including imaging guidance	for Recommended Clinical Review to		
		avoid post-service review.		
C9782	Blinded procedure for new york heart association (nyha) class ii	MP Criteria: Procedure/service reviewed	2/1/2024	12/31/2999
	or iii heart failure, or canadian cardiovascular society (ccs) class iii	against Medical Policy Criteria. Submit		
	or iv chronic refractory angina; transcatheter intramyocardial	for Recommended Clinical Review to		
	transplantation of autologous bone marrow cells (e.g.,	avoid post-service review.		
	mononuclear) or placebo control, autologous bone 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 exemption (ide)			
	study			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty,	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
	with esophagogastroduodenoscopy and intraluminal tube	by the Plan. Not subject to pre-service		
	insertion, if performed, including all system and tissue anchoring	review. Check EIU policy, which is one of		
	components	our Clinical Payment and Coding Policy		
		(CPCP).		
C9785	Endoscopic outlet reduction, gastric pouch application, with	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
	endoscopy and intraluminal tube insertion, if performed,	by the Plan. Not subject to pre-service		
	including all system and tissue anchoring components	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9793	3d predictive model generation for pre-planning of a cardiac	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	procedure, using data from cardiac computed tomographic	against Medical Policy Criteria. Submit		
	angiography and/or magnetic resonance imaging with report	for Recommended Clinical Review to		
		avoid post-service review.		
C9796	Repair of enterocutaneous fistula small intestine or colon	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
	(excluding anorectal fistula) with plug (e.g., porcine small	by the Plan. Not subject to pre-service		
	intestine submucosa [sis])	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	peripheral nerve stimulation system), including electrode and all	against Medical Policy Criteria. Submit		
	disposable system components, non-opioid medical device (must	for Recommended Clinical Review to		
	be a qualifying medicare non-opioid medical device for post-	avoid post-service review.		
	surgical pain relief in accordance with section 4135 of the caa,			
	2023)			
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	max, cryoice cryosphere, cryoice cryo2), including probe and all	against Medical Policy Criteria. Submit		
	disposable system components, non-opioid medical device (must			
	be a qualifying medicare non-opioid medical device for post-	avoid post-service review.		
	surgical pain relief in accordance with section 4135 of the caa,			
	2023)			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
	the caa, 2023)	avoia post service review.		
D0372	intraoral tomosynthesis? comprehensive series of radiographic images	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0373	intraoral tomosynthesis? bitewing radiographic image	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0374	intraoral tomosynthesis ? periapical radiographic image	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0387	intraoral tomosynthesis? comprehensive series of radiographic images - image capture only	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0388	intraoral tomosynthesis? bitewing radiographic image - image capture only	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0389	intraoral tomosynthesis ? periapical radiographic image - image capture only	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0396	3D printing of a 3D dental surface scan	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
D0801	3D intraoral surface scan - direct	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
D0802	3D dental surface scan ? indirect	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
D0803	3D facial surface scan ? direct	Non Covered: Procedure/service not	1/1/2023	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
D0804	3D facial surface scan ? indirect	Non Covered: Procedure/service not	1/1/2023	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
D1301	Immunization counseling	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
D1705	AstraZeneca Covid-19 vaccine administration ? first dose	Non Covered: Procedure/service not	3/15/2021	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
D1706	AstraZeneca Covid-19 vaccine administration ? second dose	Non Covered: Procedure/service not	3/15/2021	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
D2989	excavation of a tooth resulting in the determination of non-	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	restorability	covered by the Plan. Not subject to pre-		
		service review.		
D2991	application of hydroxyapatite regeneration medicament - per	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	tooth	covered by the Plan. Not subject to pre-		
		service review.		
D6105	removal of implant body not requiring bone removal nor flap	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	elevation	covered by the Plan. Not subject to pre-		
		service review.		
D6197	replacement of restorative material used to close an access	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	opening of a screw-retained implant supported prosthesis, per	covered by the Plan. Not subject to pre-		
	implant	service review.		
D7939	indexing for osteotomy using dynamic robotic assisted or	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	dynamic navigation	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	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
D9955	oral appliance therapy (OAT) titration visit	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
D9956	administration of home sleep apnea test	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
D9957	screening for sleep related breathing disorders	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
D9959	unspecified sleep apnea services procedure, by report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0152	Walker, battery powered, wheeled, folding, adjustable or fixed height	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
E0181	POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY	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
E0182	PUMP FOR ALTERNATING PRESSURE PAD, FOR 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
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty	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
E0184	Dry pressure mattress	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
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0186	Air pressure mattress	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
E0187	Water pressure mattress	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
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E0193	Powered air flotation bed (low air loss therapy)	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
E0194	Air fluidized bed	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
E0196	Gel pressure mattress	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
E0217	Water circulating heat pad with pump	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E0218	Fluid circulating cold pad with pump, any type	MP Criteria: Procedure/service reviewed	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E0221	Infrared heating pad system	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
		by the Plan. 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	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E0231	Non-contact wound warming device (temperature control unit,	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	ac adapter and power cord) for use with warming card and	by the Plan. Not subject to pre-service		
	wound cover	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	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	device and non contact wound warming wound cover	by the Plan. 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	9/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0239	Hydrocollator unit, portable	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
E0240	Bath/shower chair, with or without wheels, any size	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0241	Bath tub wall rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0242	Bath tub rail, floor base	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0247	Transfer bench for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E0249	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	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
E0250	Hospital bed, fixed height, with any type side rails, with mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0251	Hospital bed, fixed height, with any type side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	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
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	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
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	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
E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress	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
E0271	Mattress, innerspring	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
E0272	Mattress, foam rubber	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0273	Bed board	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
E0274	Over-bed table	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
E0277	Powered pressure-reducing air mattress	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
E0280	Bed cradle, any type	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
E0290	Hospital bed, fixed height, without side rails, with mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0291	Hospital bed, fixed height, without side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	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
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	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
E0296	Hospital bed, total electric (head, foot and height adjustments). Without side rails, with mattress	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
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	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
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	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
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	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
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	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
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	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
E0315	Bed accessory: board, table, or support device, any type	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	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
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD,	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
E0329	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES,	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
E0373	Nonpowered advanced pressure reducing mattress	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
E0468		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
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	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).	5/15/2025	12/31/2999
E0471	Respiratory assist device, bi-level pressure capability, with back- up rate feature, used with noninvasive interface, e. G., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
E0481	Intrapulmonary percussive ventilation system and related accessories	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
E0482	Cough stimulating device, alternating positive and negative airway pressure	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
E0483	High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each	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
E0484	Oscillatory positive expiratory pressure device, non-electric, any type, each	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	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
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	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
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90- day supply	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
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90- day supply	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
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	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
E0616	·	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2007	12/31/2999
E0617		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
E0620	Skin piercing device for collection of capillary blood, laser, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E0625	Patient lift, bathroom or toilet, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2010	12/31/2999
E0627	Seat lift mechanism, electric, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2010	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0629	Seat lift mechanism, non-electric, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2010	12/31/2999
E0635	Patient lift, electric with seat or sling	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
E0636	Multipositional patient support system, with integrated lift, patient accessible controls	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
E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
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 Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0640	Patient lift, fixed system, includes all components/accessories	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
E0641	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	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
E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	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
E0650	Pneumatic compressor, non-segmental home model	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
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	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
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	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
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	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
E0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0672	Segmental gradient pressure pneumatic appliance, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0673	Segmental gradient pressure pneumatic appliance, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral 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).	12/1/2020	12/31/2999
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	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
E0677	Non-pneumatic sequential compression garment, trunk	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
E0678	Non-pneumatic sequential compression garment, full leg	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
E0679	Non-pneumatic sequential compression garment, half leg	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	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
E0681	Non-pneumatic compression controller without calibrated gradient pressure	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
E0682	Non-pneumatic sequential compression garment, full arm	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
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump	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
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2008	12/31/2999
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2008	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2008	12/31/2999
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 Clinical Review to avoid post-service review.	1/15/2008	12/31/2999
E0705	Transfer device, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	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
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	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
E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/25/2013	12/31/2999
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	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).	5/15/2025	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 preservice 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application	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
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).	9/1/2020	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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 Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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
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).	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E0840	Traction frame, attached to headboard, cervical traction	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO	by the Plan. Not subject to pre-service		
	OTHER THAN MANDIBLE	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
E0850	Traction stand, free standing, cervical traction	EIU: Procedure/service not reimbursed	9/1/2020	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	12/15/2014	12/31/2999
	frame	by the Plan. 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	12/15/2014	12/31/2999
		by the Plan. 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	9/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0890	Traction frame, attached to footboard, pelvic 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).	12/15/2014	12/31/2999
E0920	Fracture frame, attached to bed, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY	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
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	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
E0941	Gravity assisted traction device, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0942	Cervical head harness/halter	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	9/1/2020	12/31/2999
E0944	Pelvic belt/harness/boot	(CPCP).  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	9/1/2020	12/31/2999
E0946	Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster)	(CPCP).  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0947	Fracture frame, attachments for complex pelvic traction	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
E0948	Fracture frame, attachments for complex cervical traction	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
E0950	Wheelchair accessory, tray, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E0953	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each	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
E0954	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot	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
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, 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
E0969	Narrowing device, wheelchair	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
E0981	Wheelchair accessory, seat upholstery, replacement only, 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
E0982	Wheelchair accessory, back upholstery, replacement only, 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	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
E0984	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	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
E0985	Wheelchair accessory, seat lift mechanism	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
E0986	Manual wheelchair accessory, push-rim activated power assist system	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
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	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
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E0992	Manual wheelchair accessory, solid seat insert	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
E1002	Wheelchair accessory, power seating system, tilt only	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
E1003	Wheelchair accessory, power seating system, recline only, 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
E1004	Wheelchair accessory, power seating system, recline only, 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
E1005	Wheelchair accessory, power seatng system, recline only, with power shear reduction	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
E1006	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1007	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
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1035	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
E1036	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
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 Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1060	Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating legrests	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
E1070	Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable footrest	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1083	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest	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
E1084	Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests	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
E1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	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
E1086	Hemi-wheelchair detachable arms desk or full length, swing away detachable footrests	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
E1087	High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests	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
E1088	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1089	High strength lightweight wheelchair, fixed length arms, swing away detachable footrest	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
E1090	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests	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
E1092	Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests	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
E1093	Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable footrests	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
E1100	Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	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
E1110	Semi-reclining wheelchair, detachable arms (desk or full length) elevating leg rest	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1130	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	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
E1140	Wheelchair, detachable arms, desk or full length, swing away detachable footrests	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
E1150	Wheelchair, detachable arms, desk or full length swing away detachable elevating legrests	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
E1160	Wheelchair, fixed full length arms, swing away detachable elevating legrests	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
E1161	Manual adult size wheelchair, includes tilt in space	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
E1170	Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1171	Amputee wheelchair, fixed full length arms, without footrests or legrest	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
E1172	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest	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
E1180	Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests	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
E1190	Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating legrests	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
E1195	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
E1200	Amputee wheelchair, fixed full length arms, swing away detachable footrest	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E1220	Wheelchair; specially sized or constructed, (indicate brand name,	MP Criteria: Procedure/service reviewed	9/15/2006	12/31/2999
	model number, if any) and justification	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1221	Wheelchair with fixed arm, footrests	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1222	Wheelchair with fixed arm, elevating legrests	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1223	Wheelchair with detachable arms, footrests	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1224	Wheelchair with detachable arms, elevating legrests	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1225	Wheelchair accessory, manual semi-reclining back, (recline	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
	greater than 15 degrees, but less than 80 degrees), each	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E1225		against Medical Policy Criteria. Submit for Recommended Clinical Review to	3/15/2014	

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), 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
E1227	Special height arms for wheelchair	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
E1228	Special back height for wheelchair	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
E1229	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	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
E1230	Power operated vehicle (three or four wheel nonhighway) specify brand name and model number	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
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	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
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	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
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	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
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	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
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	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
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system	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
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	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
E1240	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest	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
E1250	Lightweight wheelchair, fixed full length arms, swing away detachable footrest	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
E1260	Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest	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
E1270	Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E1280	Heavy duty wheelchair, detachable arms (desk or full length) elevating legrests	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
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	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
E1290	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest	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
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	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
E1296	Special wheelchair seat height from floor	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
E1297	Special wheelchair seat depth, by upholstery	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E1298	Special wheelchair seat depth and/or width, by construction	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
E1300	Whirlpool, portable (overtub type)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E1301	Whirlpool tub, walk-in, portable	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
E1310	Whirlpool, non-portable (built-in type)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E1629	Tablo hemodialysis system for the billable dialysis service	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
E1632	Wearable artificial kidney, 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).	1/1/2023	12/31/2999
E1700	Jaw motion rehabilitation system	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1701	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	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
E1702	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	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
E1902	Communication board, non-electronic augmentative or alternative communication device	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
E1905	Virtual reality cognitive behavioral therapy device (cbt), including pre-programmed therapy software	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
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	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
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	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
E2202	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	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
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	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
E2206	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, 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
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, 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
E2209	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	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
E2211	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E2212	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, 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
E2213	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, 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
E2214	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, 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
E2215	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, 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
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, 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
E2217	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E2218	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, 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
E2219	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, 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
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, 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
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, 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
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, 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
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	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
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	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
E2291	Back, planar, for pediatric size wheelchair including fixed attaching 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
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching 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
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching 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
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	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
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	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
E2301	Wheelchair accessory, power standing system, any type	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
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, 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
E2311	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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	interface, electronic, proportional, including all related	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	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
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	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
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	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
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	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
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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 Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
	INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING	against Medical Policy Criteria. Submit		
	CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED	for Recommended Clinical Review to		
	ELECTRONICS AND FIXED MOUNTING HARDWARE,	avoid post-service review.		
52275	REPLACEMENT ONLY	14D 0 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2/45/2044	12/21/2000
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
	CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND	against Medical Policy Criteria. Submit		
	MOUNTING HARDWARE, REPLACEMENT ONLY	for Recommended Clinical Review to		
		avoid post-service review.		
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	against Medical Policy Criteria. Submit		
	HARDWARE, REPLACEMENT ONLY	for Recommended Clinical Review to		
		avoid post-service review.		
52277	DOWER WHITE CHAIR ACCESSORY EVRANDARIE CONTROLLER	NAD Cuitania Duranduna/annia naviawad	2/45/2044	12/21/2000
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	against Medical Policy Criteria. Submit for Recommended Clinical Review to		
	HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	avoid post-service review.		
		avoid post-service review.		
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY,	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	EACH	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
E2402	Negative pressure wound therapy electrical pump, stationary or	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	portable	against Medical Policy Criteria. Submit	, ,	, = , = = = =
	ľ	for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2511	Speech generating software program, for personal computer or personal digital assistant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2512	Accessory for speech generating device, mounting system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E2513	Accessory for speech generating device, electromyographic sensor	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2024	12/31/2999
E2599	Accessory for speech generating device, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2007	12/31/2999
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	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
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	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
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	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
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	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
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	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
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	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
E2610	WHEELCHAIR SEAT CUSHION, POWERED	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
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE 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
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR- LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE 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
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR- LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE 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
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 Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2620	· ·	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
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	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
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	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
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	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
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	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
E2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	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
E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	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
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	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
E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	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
E2631	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	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
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	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
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
E3000	Speech volume modulation system, any type, including all components and accessories	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
E3200	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only	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
G0127	Trimming of dystrophic nails, any number	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
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	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
G0166	External counterpulsation, per treatment 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
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2011	12/31/2999
G0255	Current perception threshold/sensory nerve conduction test, (snct) per limb, any 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).	12/15/2014	12/31/2999
G0276	Blinded procedure for lumbar stenosis, percutaneous image- guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	covered by the Plan. Not subject to pre-	1/1/2015	12/31/2999
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	by the Plan. Not subject to pre-service review. Check EIU policy, which is one of	9/1/2020	12/31/2999
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in g0281	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
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/15/2016	12/31/2999
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses	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
G0302	Pre-operative pulmonary surgery services for preparation for lvrs, complete course of services, to include a minimum of 16 days of services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
G0303	Pre-operative pulmonary surgery services for preparation for lvrs, 10 to 15 days of services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
G0304	Pre-operative pulmonary surgery services for preparation for lvrs, 1 to 9 days of services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
G0305	Post-discharge pulmonary surgery services after lvrs, minimum of 6 days of services	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
G0310	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time (this code is used for medicaid billing purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999
G0311	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time (this code is used for medicaid billing purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0312		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time (this code is used for medicaid billing purposes)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999
G0314	Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 16-30 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999
G0315	Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 5-15 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/11/2022	12/31/2999
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary 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 any time unit less than 15 minutes)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary 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 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary 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 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 any time unit less than 15 minutes)		1/1/2023	12/31/2999
G0329	Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care	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
G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	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
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	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
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	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
G0372	PHYSICIAN SERVICE REQUIRED TO ESTABLISH AND DOCUMENT THE NEED FOR A POWER MOBILITY DEVICE (USE IN ADDITION TO PRIMARY EVALUATION AND MANAGEMENT CODE)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/25/2005	12/31/2999
G0422	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
G0423	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	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
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	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
G0448	INSERTION OR REPLACEMENT OF A PERMANENT PACING CARDIOVERTER-DEFIBRILLATOR SYSTEM WITH TRANSVENOUS LEAD(S), SINGLE OR DUAL CHAMBER WITH INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM, FOR LEFT VENTRICULAR PACING	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
G0455	Preparation with instillation of fecal microbiota by any method, 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
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per 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).	12/1/2020	12/31/2999
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per 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).	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
G0516		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
G0518	implants, 4 or more (services for subdermal implants)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G0556	Advanced primary care management services for a patient with	Non Covered: Procedure/service not	1/1/2025	12/31/2999
	one chronic condition [expected to last at least 12 months, or	covered by the Plan. Not subject to pre-		
	until the death of the patient, which place the patient at	service review.		
	significant risk of death, acute exacerbation/decompensation, or			
	functional decline], or fewer, provided by clinical staff and			
	directed by a physician or other qualified health care professional			
	who is responsible for all primary care and serves as the			
	continuing focal point for all needed health care services, per			
	calendar month, with the following elements, as appropriate:			
	consent; ++ inform the patient of the availability of the service;			
	that only one practitioner can furnish and be paid for the service			
	during a calendar month; of the right to stop the services at any			
	time (effective at the end of the calendar month); and that cost			
	sharing may apply. ++ document in patient's medical record that			
	consent was obtained. initiation during a qualifying visit for			
	new patients or patients not seen within 3 years; provide 24/7			
	access for urgent needs to care team/practitioner, including			
	providing patients/caregivers with a way to contact health care			
	professionals in the practice to discuss urgent needs regardless of			
	the time of day or day of week; continuity of care with a			
	designated member of the care team with whom the patient is			
	able to schedule successive routine appointments; deliver care			
	in alternative ways to traditional office visits to best meet the			
	patient's needs, such as home visits and/or expanded hours;			
	overall comprehensive care management; ++ systematic needs			
	assessment (medical and psychosocial). ++ system-based			
	approaches to ensure receipt of preventive services. ++			
	medication reconciliation, management and oversight of self-			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G0557	Advanced primary care management services for a patient with	Non Covered: Procedure/service not	1/1/2025	12/31/2999
	multiple (two or more) chronic conditions expected to last at	covered by the Plan. Not subject to pre-		
	least 12 months, or until the death of the patient, which place	service review.		
	the patient at significant risk of death, acute			
	exacerbation/decompensation, or functional decline, provided by			
	clinical staff and directed by a physician or other qualified health			
	care professional who is responsible for all primary care and			
	serves as the continuing focal point for all needed health care			
	services, per calendar month, with the following elements, as			
	appropriate: consent; ++ inform the patient of the availability			
	of the service; that only one practitioner can furnish and be paid			
	for the service during a calendar month; of the right to stop the			
	services at any time (effective at the end of the calendar month);			
	and that cost sharing may apply. ++ document in patient's			
	medical record that consent was obtained. initiation during a			
	qualifying visit for new patients or patients not seen within 3			
	years; provide 24/7 access for urgent needs to care			
	team/practitioner, including providing patients/caregivers with a			
	way to contact health care professionals in the practice to discuss			
	urgent needs regardless of the time of day or day of week;			
	continuity of care with a designated member of the care team			
	with whom the patient is able to schedule successive routine			
	appointments; deliver care in alternative ways to traditional			
	office visits to best meet the patient's needs, such as home visits			
	and/or expanded hours; overall comprehensive care			
	management; ++ systematic needs assessment (medical and			
	psychosocial). ++ system-based approaches to ensure receipt of			
	preventive services. ++ medication reconciliation, management			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G0558	Advanced primary care management services for a patient that is	Non Covered: Procedure/service not	1/1/2025	12/31/2999
	a qualified medicare beneficiary with multiple (two or more)	covered by the Plan. Not subject to pre-		
	chronic conditions expected to last at least 12 months, or until	service review.		
	the death of the patient, which place the patient at significant			
	risk of death, acute exacerbation/decompensation, or functional			
	decline, provided by clinical staff and directed by a physician or			
	other qualified health care professional who is responsible for all			
	primary care and serves as the continuing focal point for all			
	needed health care services, per calendar month, with the			
	following elements, as appropriate: consent; ++ inform the			
	patient of the availability of the service; that only one			
	practitioner can furnish and be paid for the service during a			
	calendar month; of the right to stop the services at any time			
	(effective at the end of the calendar month); and that cost			
	sharing may apply. ++ document in patient's medical record that			
	consent was obtained. initiation during a qualifying visit for			
	new patients or patients not seen within 3 years; provide 24/7			
	access for urgent needs to care team/practitioner, including			
	providing patients/caregivers with a way to contact health care			
	professionals in the practice to discuss urgent needs regardless of			
	the time of day or day of week; continuity of care with a			
	designated member of the care team with whom the patient is			
	able to schedule successive routine appointments; deliver care			
	in alternative ways to traditional office visits to best meet the			
	patient's needs, such as home visits and/or expanded hours;			
	overall comprehensive care management; ++ systematic needs			
	assessment (medical and psychosocial). ++ system-based			
	approaches to ensure receipt of preventive services. ++			
G0561	Tympanostomy with local or topical anesthesia and insertion of a	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	ventilating tube when performed with tympanostomy tube	against Medical Policy Criteria. Submit		
	delivery device, unilateral (list separately in addition to 69433)	for Recommended Clinical Review to		
	(do not use in conjunction with 0583t)	avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G2011	Alcohol and/or substance (other than tobacco) misuse structured	Non Covered: Procedure/service not	1/1/2019	12/31/2999
	assessment (e.g., audit, dast), and brief intervention, 5-14	covered by the Plan. Not subject to pre-		
	minutes	service review.		
G2082	Office or other outpatient visit for the evaluation and	MP Criteria: Procedure/service reviewed	8/1/2021	12/31/2999
	management of an established patient that requires the	against Medical Policy Criteria. Submit		
	supervision of a physician or other qualified health care	for Recommended Clinical Review to		
	professional and provision of up to 56 mg of esketamine nasal	avoid post-service review.		
	self-administration, includes 2 hours post-administration			
	observation			
G2083	Office or other outpatient visit for the evaluation and	MP Criteria: Procedure/service reviewed	8/1/2021	12/31/2999
	management of an established patient that requires the	against Medical Policy Criteria. Submit		
	supervision of a physician or other qualified health care	for Recommended Clinical Review to		
	professional and provision of greater than 56 mg esketamine	avoid post-service review.		
	nasal self-administration, includes 2 hours post-administration			
	observation			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a personcentered 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.)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for g3002. when using g3003, 15 minutes must be met or exceeded.)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G8399	Patient with documented results of a central dual-energy x-ray	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	absorptiometry (dxa) ever being performed	covered by the Plan. Not subject to pre-		
		service review.		
G8400	Patient with central dual-energy x-ray absorptiometry (dxa)	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	results not documented, reason not given	covered by the Plan. Not subject to pre-		
		service review.		
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	DOCUMENTED	covered by the Plan. Not subject to pre-		
		service review.		
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	Non Covered: Procedure/service not	1/1/2008	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not	1/1/2008	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
G8415	FOOTWEAR EVALUATION WAS NOT PERFORMED	Non Covered: Procedure/service not	1/1/2008	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
G8416	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	CANDIDATE FOR FOOTWEAR	covered by the Plan. Not subject to pre-		
		service review.		
G8417	Bmi is documented above normal parameters and a follow-up	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	plan is documented	covered by the Plan. Not subject to pre-		
		service review.		
G8418	Bmi is documented below normal parameters and a follow-up	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	plan is documented	covered by the Plan. Not subject to pre-		
		service review.		
G8419	Bmi documented outside normal parameters, no follow-up plan	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	documented, no reason given	covered by the Plan. Not subject to pre-		
		service review.		
G8420	Bmi is documented within normal parameters and no follow-up	Non Covered: Procedure/service not	1/1/2008	12/31/2999
	plan is required	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G8421	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2008	12/31/2999
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 preservice review.	1/1/2008	12/31/2999
G8428	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 the Plan. Not subject to preservice review.	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 preservice 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 preservice 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 preservice review.	1/1/2008	12/31/2999
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice review.	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2006	12/31/2999
G9051	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9053	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9056	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicareapproved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9058	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9059	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	guidelines because the patient, after being offered treatment	covered by the Plan. Not subject to pre-		
	consistent with guidelines, has opted for alternative treatment or	service review.		
	management, including no treatment (for use in a medicare-			
	approved demonstration project)			
G9060	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	guidelines for reason(s) associated with patient comorbid illness	covered by the Plan. Not subject to pre-		
	or performance status not factored into guidelines (for use in a	service review.		
	medicare-approved demonstration project)			
G9061	Oncology; practice guidelines; patient's condition not addressed	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	by available guidelines (for use in a medicare-approved	covered by the Plan. Not subject to pre-		
	demonstration project)	service review.		
G9062	Oncology; practice guidelines; management differs from	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	guidelines for other reason(s) not listed (for use in a medicare-	covered by the Plan. Not subject to pre-		
	approved demonstration project)	service review.		
G9063	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	extent of disease initially established as stage i (prior to neo-	covered by the Plan. Not subject to pre-		
	adjuvant therapy, if any) with no evidence of disease	service review.		
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			
G9064	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	extent of disease initially established as stage ii (prior to neo-	covered by the Plan. Not subject to pre-		
	adjuvant therapy, if any) with no evidence of disease	service review.		
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			
G9065	Oncology; disease status; limited to non-small cell lung cancer;	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	extent of disease initially established as stage iii a (prior to neo-	covered by the Plan. Not subject to pre-		
	adjuvant therapy, if any) with no evidence of disease	service review.		
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G9066	Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9067	Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9068	Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9069	cell and combined small cell/non-small cell; extensive stage at	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9070	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9071	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G9072	Oncology; disease status; invasive female breast cancer (does not	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as	covered by the Plan. Not subject to pre-		
	predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and	service review.		
	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	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as	covered by the Plan. Not subject to pre-		
	predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er	service review.		
	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	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as	covered by the Plan. Not subject to pre-		
	predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er	service review.		
	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	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	include ductal carcinoma in situ); adenocarcinoma as	covered by the Plan. Not subject to pre-		
	predominant cell type; m1 at diagnosis, metastatic, locally	service review.		
	recurrent, or progressive (for use in a medicare-approved			
	demonstration project)			
G9077	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7	covered by the Plan. Not subject to pre-		
	and psa < or equal to 20 at diagnosis with no evidence of disease	service review.		
	progression, recurrence, or metastases (for use in a medicare-			
	approved demonstration project)			
G9078	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10	covered by the Plan. Not subject to pre-		
	or psa > 20 at diagnosis with no evidence of disease progression,	service review.		
	recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9079	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	adenocarcinoma as predominant cell type; t3b-t4, any n; any t,	covered by the Plan. Not subject to pre-		
	n1 at diagnosis with no evidence of disease progression,	service review.		
	recurrence, or metastases (for use in a medicare-approved			
	demonstration project)			
G9080	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	adenocarcinoma; after initial treatment with rising psa or failure	covered by the Plan. Not subject to pre-		
	of psa decline (for use in a medicare-approved demonstration	service review.		
	project)			
G9083	Oncology; disease status; prostate cancer, limited to	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	adenocarcinoma; extent of disease unknown, staging in progress,	covered by the Plan. Not subject to pre-		
	or not listed (for use in a medicare-approved demonstration	service review.		
	project)			
G9084	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	covered by the Plan. Not subject to pre-		
	disease initially established as t1-3, n0, m0 with no evidence of	service review.		
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9085	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	covered by the Plan. Not subject to pre-		
	disease initially established as t4, n0, m0 with no evidence of	service review.		
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9086	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; extent of	covered by the Plan. Not subject to pre-		
	disease initially established as t1-4, n1-2, m0 with no evidence of	service review.		
	disease progression, recurrence, or metastases (for use in a			
	medicare-approved demonstration project)			
G9087	Oncology; disease status; colon cancer, limited to invasive	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	cancer, adenocarcinoma as predominant cell type; m1 at	covered by the Plan. Not subject to pre-		
	diagnosis, metastatic, locally recurrent, or progressive with	service review.		
	current clinical, radiologic, or biochemical evidence of disease			
	(for use in a medicare-approved demonstration project)			

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G9088	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9089	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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9090	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9091	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9092	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially 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 medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G9093	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicareapproved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9094	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9095	Oncology; disease status; rectal 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially 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 medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
G9099	adenocarcinoma or squamous cell carcinoma as predominant cell	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9100	adenocarcinoma as predominant cell type; post r0 resection	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9101	adenocarcinoma as predominant cell type; post r1 or r2 resection	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9102	adenocarcinoma as predominant cell type; clinical or pathologic	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9103	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9104		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9105	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9106	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicareapproved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9107	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9108	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9109	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9110	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G9111	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9112	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9113	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9114	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9115	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9116	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
G9117	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G9123	Oncology; disease status; chronic myelogenous leukemia, limited	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	to philadelphia chromosome positive and/or bcr-abl positive;	covered by the Plan. Not subject to pre-		
	chronic phase not in hematologic, cytogenetic, or molecular	service review.		
	remission (for use in a medicare-approved demonstration			
	project)			
G9124	Oncology; disease status; chronic myelogenous leukemia, limited	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	to philadelphia chromosome positive and/or bcr-abl positive;	covered by the Plan. Not subject to pre-		
	accelerated phase not in hematologic cytogenetic, or molecular	service review.		
	remission (for use in a medicare-approved demonstration			
	project)			
G9125	Oncology; disease status; chronic myelogenous leukemia, limited	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	to philadelphia chromosome positive and/or bcr-abl positive;	covered by the Plan. Not subject to pre-		
	blast phase not in hematologic, cytogenetic, or molecular	service review.		
	remission (for use in a medicare-approved demonstration			
	project)			
G9126	Oncology; disease status; chronic myelogenous leukemia, limited	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	to philadelphia chromosome positive and/or bcr-abl positive; in	covered by the Plan. Not subject to pre-		
	hematologic, cytogenetic, or molecular remission (for use in a	service review.		
	medicare-approved demonstration project)			
G9128	Oncology; disease status; limited to multiple myeloma, systemic	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	disease; smoldering, stage i (for use in a medicare-approved	covered by the Plan. Not subject to pre-		
	demonstration project)	service review.		
G9129	Oncology; disease status; limited to multiple myeloma, systemic	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	disease; stage ii or higher (for use in a medicare-approved	covered by the Plan. Not subject to pre-		
	demonstration project)	service review.		
G9130	Oncology; disease status; limited to multiple myeloma, systemic	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	disease; extent of disease unknown, staging in progress, or not	covered by the Plan. Not subject to pre-		
	listed (for use in a medicare-approved demonstration project)	service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD 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	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2007	12/31/2999
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	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
G9886	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
G9887	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
G9888	Maintenance 5% wl from baseline weight in months 7-12	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
H0031	Mental health assessment, by non-physician	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
H0032	Mental health service plan development by non-physician	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
H0038	Self-help/peer services, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0039	Assertive community treatment, face-to-face, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0040	Assertive community treatment program, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0041	Foster care, child, non-therapeutic, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0042	Foster care, child, non-therapeutic, per month	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0043	Supported housing, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0044	Supported housing, per month	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0045	Respite care services, not in the home, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H0051	Traditional healing service	Non Covered: Procedure/service not	4/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H1010	Non-medical family planning education, per session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H1011	Family assessment by licensed behavioral health professional for		1/1/1950	12/31/2999
	state defined purposes	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
H2000	Comprehensive multidisciplinary evaluation	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2011	Crisis intervention service, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2012	Behavioral health day treatment, per hour	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2013	Psychiatric health facility service, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2014	Skills training and development, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2015	Comprehensive community support services, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2016	Comprehensive community support services, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2021	Community-based wrap-around services, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2022	Community-based wrap-around services, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2023	Supported employment, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2024	Supported employment, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
H2025	Ongoing support to maintain employment, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2026	Ongoing support to maintain employment, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2027	Psychoeducational service, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2028	Sexual offender treatment service, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2029	Sexual offender treatment service, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2030	Mental health clubhouse services, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2031	Mental health clubhouse services, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2032	Activity therapy, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2033	Multisystemic therapy for juveniles, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2034	Alcohol and/or drug abuse halfway house services, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
H2037	Developmental delay prevention activities, dependent child of	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	client, per 15 minutes	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J0174	Injection, lecanemab-irmb, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/6/2023	12/31/2999
J0175	Injection, donanemab-azbt, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/2/2024	12/31/2999
J0177	Injection, aflibercept hd, 1 mg	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
J0178	Injection, aflibercept, 1 mg	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
J0179	Injection, brolucizumab-dbll, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J0215	Injection, alefacept, 0. 5 mg	MP Criteria: Procedure/service reviewed	2/29/2016	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J0217	Injection, velmanase alfa-tycv, 1 mg	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed	4/1/2022	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE	MP Criteria: Procedure/service reviewed	7/1/2014	12/31/2999
	SPECIFIED	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed	7/1/2021	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
J0223	Injection, givosiran, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
J0224	Injection, lumasiran, 0.5 mg	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
J0225	Injection, vutrisiran, 1 mg	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
J0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
J0270	Injection, alprostadil, 1. 25 mcg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2014	12/31/2999
J0275	Alprostadil urethral suppository (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J0470	Injection, dimercaprol, per 100 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
J0485	Injection, belatacept, 1 mg	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
J0491	Injection, anifrolumab-fnia, 1 mg	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
J0517	Injection, benralizumab, 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
J0585	INJECTION, ONABOTULINUMTOXINA, 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
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	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
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	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
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
J0895	Injection, deferoxamine mesylate, 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2007	12/31/2999
J1071	Injection, testosterone cypionate, 1mg	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
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed	1/1/2019	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed	10/1/2022	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed	7/15/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed	10/1/2021	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1306	Injection, inclisiran, 1 mg	MP Criteria: Procedure/service reviewed	7/1/2022	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J1307	Injection, crovalimab-akkz, 10 mg	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1323	Injection, elranatamab-bcmm, 1 mg	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1325	Injection, epoprostenol, 0. 5 mg	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	MP Criteria: Procedure/service reviewed	4/1/2023	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	nominal 2 x 10^13 vector genomes	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	dose	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
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Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose	MP Criteria: Procedure/service reviewed	1/1/2025	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed	10/1/2021	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed	5/1/2021	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose  Injection, casimersen, 10 mg  Injection, viltolarsen, 10 mg  Injection, eteplirsen, 10 mg  Injection, golodirsen, 10 mg	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose  MP Criteria: Procedure/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.  Injection, golodirsen, 10 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service 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	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed.  Injection, casimersen, 10 mg  MP Criteria: Procedure/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.  Injection, viltolarsen, 10 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed.  Injection, eteplirsen, 10 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, golodirsen, 10 mg  MP Criteria: Procedure/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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1552	Injection, immune globulin (alyglo), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
J1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 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
J1628	Injection, guselkumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
J1632	Injection, brexanolone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	2/14/2025
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	7/15/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	7/15/2023	12/31/2999
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1811	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units	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
J1812	Insulin (fiasp), per 5 units	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
J1813	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units	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
J1814	Insulin (lyumjev), per 5 units	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
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
J1930	INJECTION, LANREOTIDE, 1 MG	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
J1932	Injection, lanreotide, (cipla), 1 mg	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
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2024	12/31/2999
J2329	Injection, ublituximab-xiiy, 1mg	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
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	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

Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Injection, octreotide, non-depot form for subcutaneous or	MP Criteria: Procedure/service reviewed	3/1/2024	12/31/2999
intravenous injection, 25 mcg	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed	7/1/2022	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, papaverine hcl, up to 60 mg	MP Criteria: Procedure/service reviewed	2/15/2007	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, pasireotide long acting, 1 mg	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, faricimab-svoa, 0.1 mg	MP Criteria: Procedure/service reviewed	10/1/2022	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg  Injection, tezepelumab-ekko, 1 mg  Injection, papaverine hcl, up to 60 mg  Injection, pasireotide long acting, 1 mg  Injection, pegunigalsidase alfa-iwxj, 1 mg	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg  MP Criteria: Procedure/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.  Injection, pegunigalsidase alfa-iwxj, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service 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	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, tezepelumab-ekko, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service reviewed.  Injection, papaverine hcl, up to 60 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, pasireotide long acting, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review to avoid post-service review.  Injection, pegunigalsidase alfa-iwxi, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, faricimab-svoa, 0.1 mg  MP Criteria: Procedure/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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J2782	Injection, avacincaptad pegol, 0.1 mg	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
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	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
J2802	Injection, romiplostim, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999

Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Injection, talquetamab-tgvs, 0.25 mg	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, romosozumab-aqqg, 1 mg	MP Criteria: Procedure/service reviewed	3/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, testosterone enanthate, 1mg	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999 12/31/2999 12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, testosterone undecanoate, 1 mg	MP Criteria: Procedure/service reviewed	10/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed	11/1/2020	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed	8/15/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
	Injection, talquetamab-tgvs, 0.25 mg  Injection, romosozumab-aqqg, 1 mg  Injection, testosterone enanthate, 1mg  Injection, testosterone undecanoate, 1 mg  Injection, teprotumumab-trbw, 10 mg	Injection, talquetamab-tgvs, 0.25 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, romosozumab-aqqg, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, testosterone enanthate, 1mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, testosterone undecanoate, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, teprotumumab-trbw, 10 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service 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	Injection, talquetamab-tgvs, 0.25 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, romosozumab-aqqg, 1 mg  MP Criteria: Procedure/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.  Injection, testosterone undecanoate, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, teprotumumab-trbw, 10 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review to avoid post-s

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J3355	INJECTION, UROFOLLITROPIN, 75 IU	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2006	12/31/2999
J3392	Injection, exagamglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
J3393	Injection, betibeglogene autotemcel, per treatment	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
J3394	Injection, lovotibeglogene autotemcel, per treatment	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
J3396	INJECTION, VERTEPORFIN, 0.1 MG	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
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
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 Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
J3570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	6/1/2015	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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
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
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	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
J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	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
J7321	Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra- articular injection, per dose	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
J7323	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA- ARTICULAR INJECTION, PER DOSE	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
J7325	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG	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
J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE	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
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	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
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	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
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	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

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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 DME, CONCENTRATED FORM, 0.5 MG	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
.=		(CPCP).	10/1/0000	10/01/0000
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
J7622	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED	(CPCP). EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
17622	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	PER MILLIGRAM	review. Check EIU policy, which is one of		
	PEN WILLIGNAWI	our Clinical Payment and Coding Policy		
		(CPCP).		
J7624	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
, , , ,	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service	12, 1, 2020	12,32,233
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7627	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	UP TO 0.5 MG	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J7628	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7629	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER 0.25 MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7635	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER	by the Plan. Not subject to pre-service		
	MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7636	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER	by the Plan. Not subject to pre-service		
	MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J7637	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7638	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7640	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12	by the Plan. Not subject to pre-service		
	MICROGRAMS	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7641	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7642		EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT	by the Plan. Not subject to pre-service		
	DOSE FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10	by the Plan. Not subject to pre-service		
	MILLIGRAMS	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT	by the Plan. Not subject to pre-service		
	DOSE FORM, PER 10 MILLIGRAMS	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION,	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	COMPOUNDED PRODUCT, ADMINISTERED	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7680		EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	by the Plan. Not subject to pre-service		
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
J7681		EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service		
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
17000	TRIANGINGLONG INITIAL ATION COLUTION COMPOUNDED	(CPCP).	12/1/2020	12/21/2000
J7683	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service	12/1/2020	12/31/2999
	FORM, PER MILLIGRAM	review. Check EIU policy, which is one of		
	FORIVI, PER IVIILLIGRAIVI	our Clinical Payment and Coding Policy		
		(CPCP).		
J7684	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
,,,,,,	PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM,	by the Plan. Not subject to pre-service	12, 1, 2020	12,31,2333
	PER MILLIGRAM	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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).		12/31/2999
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 preservice review.	4/1/2024	3/31/2025
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 preservice review.	4/1/2024	12/31/2999
J9063	Injection, mirvetuximab soravtansine-gynx, 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
J9247	Injection, melphalan flufenamide, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	3/31/2025

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J9274	Injection, tebentafusp-tebn, 1 microgram	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
J9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	9/1/2019	12/31/2999
J9286	Injection, glofitamab-gxbm, 2.5 mg	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
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2024	12/31/2999
J9321	Injection, epcoritamab-bysp, 0.16 mg	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
J9331	Injection, sirolimus protein-bound particles, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, tremelimumab-actl, 1 mg	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, mosunetuzumab-axgb, 1 mg	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed	4/1/2024	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
Injection, teclistamab-cqyv, 0.5 mg	MP Criteria: Procedure/service reviewed	7/1/2023	12/31/2999
	against Medical Policy Criteria. Submit		
	for Recommended Clinical Review to		
	avoid post-service review.		
_	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc  Injection, tremelimumab-actl, 1 mg  Injection, mosunetuzumab-axgb, 1 mg  Injection, pozelimab-bbfg, 1 mg	against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, tremelimumab-actl, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, mosunetuzumab-axgb, 1 mg  MP Criteria: Procedure/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.  Injection, teclistamab-cqyv, 0.5 mg  MP Criteria: Procedure/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	against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc  Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, tremelimumab-actl, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, mosunetuzumab-axgb, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.  Injection, pozelimab-bbfg, 1 mg  MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review to avoid post-service review.  Injection, teclistamab-cqyv, 0.5 mg  MP Criteria: Procedure/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 against Medical Policy Criteria. Submit for Recommended Clinical Review to

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
J9381	Injection, teplizumab-mzwv, 5 mcg	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
J9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2008	12/31/2999
K0002	Standard hemi (low seat) wheelchair	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
K0003	Lightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
K0004	High strength, lightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
K0005	Ultralightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0006	Heavy duty wheelchair	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
K0007	Extra heavy duty wheelchair	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
K0008	Custom Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2016	12/31/2999
К0009	Other manual wheelchair/base	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
K0010	Standard - weight frame motorized/power wheelchair	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
K0011	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0012	Lightweight portable motorized/power wheelchair	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
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2016	12/31/2999
K0014	Other motorized/power wheelchair base	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
К0053	Elevating footrests, articulating (telescoping), 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
К0056	Seat height less than 17 or equal to or greater than 21 for a high strength, lightweight, or ultralightweight wheelchair	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
K0065	Spoke protectors, 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
K0108	Wheelchair component or accessory, not otherwise specified	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
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e. G. , epoprostenol or treprostinol)	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
K0669	Seat/back custom; no dme pdac ver	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
К0743	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999
K0745	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999
ко800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, 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.	10/1/2006	12/31/2999
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, 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.	10/1/2006	12/31/2999
К0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	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
К0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, 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.	10/1/2006	12/31/2999
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, 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.	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	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
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	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
K0813		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
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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
К0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, 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.	7/27/2009	12/31/2999
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY 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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
K0821	POWER WHEELCHAIR, GROUP 2 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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
К0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
К0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, 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.	7/27/2009	12/31/2999
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, 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
K0825		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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
K0826	, , , ,	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
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 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
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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
К0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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
К0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, 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.	7/27/2009	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
К0836	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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
К0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE 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
К0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, 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
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 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
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE 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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0843	POWER WHEELCHAIR, GROUP 2 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
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, 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.	7/27/2009	12/31/2999
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, 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
к0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 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
к0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 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
К0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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
К0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0857	POWER WHEELCHAIR, GROUP 3 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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
К0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE 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
к0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, 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
ко860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 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
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
K0862	POWER WHEELCHAIR, GROUP 3 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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 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
К0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	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
К0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
К0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, 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.	7/27/2009	12/31/2999
К0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, 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
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, 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.	7/27/2009	12/31/2999
К0878	POWER WHEELCHAIR, GROUP 4 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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE 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
К0880	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 Clinical Review to avoid post-service review.	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	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>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
K0886	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
ко890	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
К0899	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	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	and self-collected use, FDA approved, authorized or cleared, one	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	5/12/2023	12/31/2999
K1035		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2023	12/31/2999
K1036	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		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	(foam collar)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated	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
L1834	Knee orthosis, without knee joint, rigid, custom-fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2008	12/31/2999
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated	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
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	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
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	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
L1860	Knee orthosis, modification of supracondylar prosthetic socket, custom-fabricated (sk)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR	MP Criteria: Procedure/service reviewed	9/1/2014	12/31/2999
	DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND	against Medical Policy Criteria. Submit		
	SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE	for Recommended Clinical Review to		
	JOINT, ANY TYPE, CUSTOM FABRICATED	avoid post-service review.		
L3001	Foot, insert, removable, molded to patient model, spenco, each	Non Covered: Procedure/service not	5/15/2007	12/31/2999
		covered by the Plan. Not subject to preservice review.		
L3002	Foot, insert, removable, molded to patient model, plastazote or	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	equal, each	covered by the Plan. Not subject to preservice review.		
L3003	Foot, insert, removable, molded to patient model, silicone gel,	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	each	covered by the Plan. Not subject to pre-		
L3010	Foot insert removable molded to nations model longitudinal	service review.	5/15/2007	12/21/2000
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-	5/15/2007	12/31/2999
	arch support, each	service review.		
L3020	Foot, insert, removable, molded to patient model, longitudinal/	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	metatarsal support, each	covered by the Plan. Not subject to preservice review.		
L3030	Foot, insert, removable, formed to patient foot, each	Non Covered: Procedure/service not	5/15/2007	12/31/2999
		covered by the Plan. Not subject to preservice review.		
L3031	Foot, insert/plate, removable, addition to lower extremity	Non Covered: Procedure/service not	3/1/2009	12/31/2999
	orthosis, high strength, lightweight material, all hybrid	covered by the Plan. Not subject to pre-		
	lamination/prepreg composite, each	service review.		
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not	5/15/2007	12/31/2999
		covered by the Plan. Not subject to preservice review.		
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not	5/15/2007	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L3060	Foot, arch support, removable, premolded, longitudinal/	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	metatarsal, each	covered by the Plan. Not subject to pre-		
		service review.		
L3070	Foot, arch support, non-removable attached to shoe,	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	longitudinal, each	covered by the Plan. Not subject to pre-		
		service review.		
L3080	Foot, arch support, non-removable attached to shoe, metatarsal,	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	each	covered by the Plan. Not subject to pre-		
		service review.		
L3090	Foot, arch support, non-removable attached to shoe,	Non Covered: Procedure/service not	5/15/2007	12/31/2999
	longitudinal/metatarsal, each	covered by the Plan. Not subject to pre-		
		service review.		
L3100	Hallus-valgus night dynamic splint, prefabricated, off-the-shelf	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3140	Foot, abduction rotation bar, including shoes	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3150	Foot, abduction rotatation bar, without shoes	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3160	Foot, adjustable shoe-styled positioning device	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3170	Foot, plastic, silicone or equal, heel stabilizer, prafabricated, off-	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	the-shelf, each	covered by the Plan. Not subject to pre-		
		service review.		
L3201	Orthopedic shoe, oxford with supinator or pronator, infant	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3202	Orthopedic shoe, oxford with supinator or pronator, child	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L3203	Orthopedic shoe, oxford with supinator or pronator, junior	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3204	Orthopedic shoe, hightop with supinator or pronator, infant	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3206	Orthopedic shoe, hightop with supinator or pronator, child	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3207	Orthopedic shoe, hightop with supinator or pronator, junior	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3212	Benesch boot, pair, infant	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3213	Benesch boot, pair, child	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3214	Benesch boot, pair, junior	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3215	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3216	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3217	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	EACH	covered by the Plan. Not subject to pre-		
		service review.		
L3219	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L3221	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3222	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	EACH	covered by the Plan. Not subject to pre-		
		service review.		
L3224	Orthopedic footwear, woman's shoe, oxford, used as an integral	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	part of a brace (orthosis)	covered by the Plan. Not subject to pre-		
		service review.		
L3225	Orthopedic footwear, man's shoe, oxford, used as an integral	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	part of a brace (orthosis)	covered by the Plan. Not subject to pre-		
		service review.		
L3230	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3250	Orthopedic footwear, custom molded shoe, removable inner	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	mold, prosthetic shoe, each	covered by the Plan. Not subject to pre-		
		service review.		
L3251	Foot, shoe molded to patient model, silicone shoe, each	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3252	Foot, shoe molded to patient model, plastazote (or similar),	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	custom fabricated, each	covered by the Plan. Not subject to pre-		
		service review.		
L3253	Foot, molded shoe plastazote (or similar) custom fitted, each	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3254	Non-standard size or width	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3255	Non-standard size or length	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L3257	Orthopedic footwear, additional charge for split size	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3265	Plastazote sandal, each	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3300	Lift, elevation, heel, tapered to metatarsals, per inch	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3310	Lift, elevation, heel and sole, neoprene, per inch	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3320	Lift, elevation, heel and sole, cork, per inch	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3330	Lift, elevation, metal extension (skate)	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3334	Lift, elevation, heel, per inch	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3340	Heel wedge, sach	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3350	Heel wedge	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3360	Sole wedge, outside sole	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L3370	Sole wedge, between sole	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3380	Clubfoot wedge	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3390	Outflare wedge	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3400	Metatarsal bar wedge, rocker	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3410	Metatarsal bar wedge, between sole	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3420	Full sole and heel wedge, between sole	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3430	Heel, counter, plastic reinforced	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3440	Heel, counter, leather reinforced	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3450	Heel, sach cushion type	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3455	Heel, new leather, standard	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3460	Heel, new rubber, standard	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L3465	Heel, thomas with wedge	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3470	Heel, thomas extended to ball	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3480	Heel, pad and depression for spur	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3485	Heel, pad, removable for spur	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3500	Orthopedic shoe addition, insole, leather	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3510	Orthopedic shoe addition, insole, rubber	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3520	Orthopedic shoe addition, insole, felt covered with leather	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3530	Orthopedic shoe addition, sole, half	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3540	Orthopedic shoe addition, sole, full	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3550	Orthopedic shoe addition, toe tap standard	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3560	Orthopedic shoe addition, toe tap, horseshoe	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L3570	Orthopedic shoe addition, special extension to instep (leather	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	with eyelets)	covered by the Plan. Not subject to pre-		
		service review.		
L3580	Orthopedic shoe addition, convert instep to velcro closure	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3590	Orthopedic shoe addition, convert firm shoe counter to soft	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	counter	covered by the Plan. Not subject to pre-		
		service review.		
L3595	Orthopedic shoe addition, march bar	Non Covered: Procedure/service not	1/1/2006	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
L3600	Transfer of an orthosis from one shoe to another, caliper plate,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	existing	covered by the Plan. Not subject to pre-		
		service review.		
L3610	Transfer of an orthosis from one shoe to another, caliper plate,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	new	covered by the Plan. Not subject to pre-		
		service review.		
L3620	Transfer of an orthosis from one shoe to another, solid stirrup,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	existing	covered by the Plan. Not subject to pre-		
		service review.		
L3630	Transfer of an orthosis from one shoe to another, solid stirrup,	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	new	covered by the Plan. Not subject to pre-		
		service review.		
L3640	Transfer of an orthosis from one shoe to another, dennis	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	browne splint (riveton), both shoes	covered by the Plan. Not subject to pre-		
		service review.		
L3649	Orthopedic shoe, modification, addition or transfer, not	Non Covered: Procedure/service not	1/1/2006	12/31/2999
	otherwise specified	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5611	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5613	Addition to lower extremity, endoskeletal system, above kneeknee disarticulation, 4 bar linkage, with hydraulic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5614	Addition to lower extremity, exoskeletal system, above kneeknee disarticulation, 4 bar linkage, with pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	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
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L5629	Addition to lower extremity, below knee, acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5638	Addition to lower extremity, below knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5640	Addition to lower extremity, knee disarticulation, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
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 Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	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
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2007	12/31/2999
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2007	12/31/2999
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	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
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	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
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	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
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2015	12/31/2999
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	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
L5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	Effective Date	Ending Date
L5974	All lower extremity prostheses, foot, single axis ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5976	All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5980	All lower extremity prostheses, flex foot system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5981	All lower extremity prostheses, flex-walk system or equal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L5982	All exoskeletal lower extremity prostheses, axial rotation unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	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
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	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
L6621	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 Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6715	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT	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
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	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
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	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
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	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
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	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
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	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
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	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
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L6950	Above elbow, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
i	humeral shell, internal locking elbow, forearm, otto bock or	against Medical Policy Criteria. Submit		
	equal switch, cables, two batteries and one charger, switch	for Recommended Clinical Review to		
	control of terminal device	avoid post-service review.		
L6955	Above elbow, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	humeral shell, internal locking elbow, forearm, otto bock or	against Medical Policy Criteria. Submit		
	equal electrodes, cables, two batteries and one charger,	for Recommended Clinical Review to		
	myoelectronic control of terminal device	avoid post-service review.		
L6960	Shoulder disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	against Medical Policy Criteria. Submit		
	mechanical elbow, forearm, otto bock or equal switch, cables,	for Recommended Clinical Review to		
	two batteries and one charger, switch control of terminal device	avoid post-service review.		
L6965	Shoulder disarticulation, external power, molded inner socket,	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	against Medical Policy Criteria. Submit		
	mechanical elbow, forearm, otto bock or equal electrodes,	for Recommended Clinical Review to		
	cables, two batteries and one charger, myoelectronic control of terminal device	avoid post-service review.		
L6970	Interscapular-thoracic, external power, molded inner socket,	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	against Medical Policy Criteria. Submit		
	mechanical elbow, forearm, otto bock or equal switch, cables,	for Recommended Clinical Review to		
	two batteries and one charger, switch control of terminal device	avoid post-service review.		
L6975	Interscapular-thoracic, external power, molded inner socket,	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
	removable shoulder shell, shoulder bulkhead, humeral section,	against Medical Policy Criteria. Submit		
	mechanical elbow, forearm, otto bock or equal electrodes,	for Recommended Clinical Review to		
	cables, two batteries and one charger, myoelectronic control of	avoid post-service review.		
	terminal device			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	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
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	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
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	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
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	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
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	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
L7170	Electronic elbow, hosmer or equal, switch controlled	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	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
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	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
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled	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
L7186	Electronic elbow, child, variety village or equal, switch controlled	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
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	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
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L7259	Electronic wrist rotator, any type	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
L7360	Six volt battery, each	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
L7362	Battery charger, six volt, each	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
L7364	Twelve volt battery, each	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
L7366	Battery charger, twelve volt, each	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
L7367	Lithium ion battery, rechargeable, replacement	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed	7/15/2007	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
L7900	Male vacuum erection system	MP Criteria: Procedure/service reviewed	6/1/2008	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
L7902	Tension ring, for vacuum erection device, any type, replacement	MP Criteria: Procedure/service reviewed	7/1/2022	12/31/2999
	only, each	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
L8603	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml	EIU: Procedure/service not reimbursed	5/15/2024	12/31/2999
	syringe, includes shipping and necessary supplies	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer		12/1/2020	12/31/2999
	implant, anal canal, 1 ml, includes shipping and necessary	by the Plan. Not subject to pre-service		
	supplies	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).	. /. /. 050	10/01/0000
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml	MP Criteria: Procedure/service reviewed	1/1/1950	12/31/2999
	syringe, includes shipping and necessary supplies	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	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
L8609	ARTIFICIAL CORNEA	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
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	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
L8679	Implantable neurostimulator, pulse generator, any type	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
L8680	Implantable neurostimulator electrode, each	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT 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
L8682	Implantable neurostimulator radiofrequency receiver	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
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT 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
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	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
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT 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
L8698	Miscellaneous component, supply or accessory for use with total artificial heart system	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
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	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
L8720	External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg	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
L8721	Receptor sole for use with l8720, replacement, each	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
M0001	Advancing cancer care mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M0002	Optimal care for kidney health mips value pathways	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M0004	Quality care for patients with neurological conditions mips value pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M0005	Value in primary care mips value pathway	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M0076	Prolotherapy	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
M0100	Intragastric hypothermia using gastric freezing	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M0240		·	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	1 .		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
M0241		·	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	,		
	monitoring in the home or residence, this includes a beneficiary's	• • • • • • • • • • • • • • • • • • • •		
		our Clinical Payment and Coding Policy		
	the covid-19 public health emergency, subsequent repeat doses	(CPCP).		
M0243	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	by the Plan. Not subject to pre-service		
	monitoring	review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
M0244	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	by the Plan. Not subject to pre-service		
	monitoring in the home or residence; this includes a beneficiary's	review. Check EIU policy, which is one of		
	home that has been made provider-based to the hospital during	our Clinical Payment and Coding Policy		
	the covid-19 public health emergency	(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
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	3/31/2025
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	by the Plan. Not subject to pre-service	6/1/2023	3/31/2025
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	Current or prior 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 preservice review.	1/1/2023	12/31/2999
M1151	Patients with a history of heart transplant or with a left ventricular assist device (Ivad)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1152	Patients with a history of heart transplant or with a left ventricular assist device (Ivad)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice review.	1/1/2023	12/31/2999
M1160	Patient had anaphylaxis due to the meningococcal vaccine any time on or before the patient's 13th birthday	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1161	Patient had anaphylaxis due to the tetanus, diphtheria or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	pertussis vaccine any time on or before the patient's 13th	covered by the Plan. Not subject to pre-		
	birthday	service review.		
M1162	Patient had encephalitis due to the tetanus, diphtheria or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	pertussis vaccine any time on or before the patient's 13th	covered by the Plan. Not subject to pre-		
	birthday	service review.		
M1163	Patient had anaphylaxis due to the hpv vaccine any time on or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	before the patient's 13th birthday	covered by the Plan. Not subject to pre-		
		service review.		
M1164	Patients with dementia any time during the patient's history	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	through the end of the measurement period	covered by the Plan. Not subject to pre-		
		service review.		
M1165	Patients who use hospice services any time during the	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	measurement period	covered by the Plan. Not subject to pre-		
		service review.		
M1166	Pathology report for tissue specimens produced from wide local	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	excisions or re-excisions	covered by the Plan. Not subject to pre-		
		service review.		
M1167	In hospice or using hospice services during the measurement	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	period	covered by the Plan. Not subject to pre-		
		service review.		
M1168	Patient received an influenza vaccine on or between july 1 of the	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	year prior to the measurement period and june 30 of the	covered by the Plan. Not subject to pre-		
	measurement period	service review.		
M1169	Documentation of medical reason(s) for not administering	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	influenza vaccine (e.g., prior anaphylaxis due to the influenza	covered by the Plan. Not subject to pre-		
	vaccine)	service review.		
M1170	Patient did not receive an influenza vaccine on or between july 1	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	of the year prior to the measurement period and june 30 of the	covered by the Plan. Not subject to pre-		
	measurement period	service review.		
M1171	Patient received at least one td vaccine or one tdap vaccine	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	between nine years prior to the encounter and the end of the	covered by the Plan. Not subject to pre-		
	measurement period	service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1172	Documentation of medical reason(s) for not administering td or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	tdap vaccine (e.g., prior anaphylaxis due to the td or tdap vaccine	covered by the Plan. Not subject to pre-		
	or history of encephalopathy within seven days after a previous	service review.		
	dose of a td-containing vaccine)			
M1173	Patient did not receive at least one td vaccine or one tdap	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	vaccine between nine years prior to the encounter and the end	covered by the Plan. Not subject to pre-		
	of the measurement period	service review.		
M1174	Patient received at least two doses of the herpes zoster	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	recombinant vaccine (at least 28 days apart) anytime on or after	covered by the Plan. Not subject to pre-		
	the patient's 50th birthday before or during the measurement	service review.		
	period			
M1175	Documentation of medical reason(s) for not administering zoster	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	vaccine (e.g., prior anaphylaxis due to the zoster vaccine)	covered by the Plan. Not subject to pre-		
		service review.		
M1176	Patient did not receive two doses of the herpes zoster	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	recombinant vaccine (at least 28 days apart) anytime on or after	covered by the Plan. Not subject to pre-		
	the patient's 50th birthday before or during the measurement	service review.		
	period			
M1177	Patient received any pneumococcal conjugate or polysaccharide	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	vaccine on or after their 19th birthday and before the end of the	covered by the Plan. Not subject to pre-		
	measurement period	service review.		
M1178	Documentation of medical reason(s) for not administering	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	pneumococcal vaccine (e.g., prior anaphylaxis due to the	covered by the Plan. Not subject to pre-		
	pneumococcal vaccine)	service review.		
M1179	Patient did not receive any pneumococcal conjugate or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	polysaccharide vaccine, on or after their 19th birthday and	covered by the Plan. Not subject to pre-		
	before or during measurement period	service review.		
M1180	Patients on immune checkpoint inhibitor therapy	Non Covered: Procedure/service not	1/1/2023	12/31/2999
		covered by 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	1/1/2023	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1182	Patients not eligible due to pre-existing inflammatory bowel	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	disease (ibd) (e.g., ulcerative colitis, crohn's disease)	covered by the Plan. Not subject to pre-		
		service review.		
M1183	Documentation of immune checkpoint inhibitor therapy held and	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	corticosteroids or immunosuppressants prescribed or	covered by the Plan. Not subject to pre-		
	administered	service review.		
M1184	Documentation of medical reason(s) for not prescribing or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	administering corticosteroid or immunosuppressant treatment	covered by the Plan. Not subject to pre-		
	(e.g., allergy, intolerance, infectious etiology, pancreatic	service review.		
	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	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	and/or corticosteroids or immunosuppressants prescribed or	covered by the Plan. Not subject to pre-		
	administered was not performed, reason not given	service review.		
M1186	Patients who have an order for or are receiving hospice or	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	palliative care	covered by the Plan. Not subject to pre-		
		service review.		
M1187	Patients with a diagnosis of end stage renal disease (esrd)	Non Covered: Procedure/service not	1/1/2023	12/31/2999
		covered by 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	1/1/2023	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1189	Documentation of a kidney health evaluation defined by an	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	estimated glomerular filtration rate (egfr) and urine albumin-	covered by the Plan. Not subject to pre-		
	creatinine ratio (uacr) performed	service review.		
M1190	· · · · · · · · · · · · · · · · · · ·	·	1/1/2023	12/31/2999
	or defined by an estimated glomerular filtration rate (egfr) and	covered by the Plan. Not subject to pre-		
	urine albumin-creatinine ratio (uacr)	service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
M1191	Hospice services provided to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1192	Patients with an existing diagnosis of squamous cell carcinoma of the esophagus	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1193	Surgical pathology reports that contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1194	Documentation of medical reason(s) surgical pathology reports did not contain impression or conclusion of or recommendation for testing of mmr by 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1195	Surgical pathology reports that do not contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1196	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1197	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1198	Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1199	Patients receiving rrt	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1201	Documentation of medical reason(s) for not prescribing ace inhibitor (ace-i) or arb therapy during the measurement period (e.g., pregnancy, history of 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)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1202	Documentation of patient reason(s) for not prescribing ace inhibitor or arb therapy during the measurement period, (e.g., patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1203	Ace inhibitor or arb therapy not prescribed during the measurement period, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1204	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1205	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1206	Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999
M1207	Patient is screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1208	Patient is not screened for food insecurity, housing instability,	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	transportation needs, utility difficulties, and interpersonal safety	covered by the Plan. Not subject to pre-		
		service review.		
M1209	At least two orders for high-risk medications from the same drug	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	class, (table 4), without appropriate diagnoses	covered by the Plan. Not subject to pre-		
		service review.		
M1210	At least two orders for high-risk medications from the same drug	Non Covered: Procedure/service not	1/1/2023	12/31/2999
	class, (table 4), not ordered	covered by the Plan. Not subject to pre-		
		service review.		
M1211	Most recent glycemic status assessment (hba1c or gmi) level >	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	9.0%	covered by the Plan. Not subject to pre-		
		service review.		
M1212	Glycemic status assessment (hba1c or gmi) level is missing, or	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	was not performed during the measurement period	covered by the Plan. Not subject to pre-		
		service review.		
M1213	No history of spirometry results with confirmed airflow	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	obstruction (fev1/fvc < 70%) and present spirometry is >= 70%	covered by the Plan. Not subject to pre-		
		service review.		10/01/0000
M1214	Spirometry results with confirmed airflow obstruction (fev1/fvc <		1/1/2024	12/31/2999
	70%) documented and reviewed	covered by the Plan. Not subject to pre-		
14245		service review.	4 /4 /2024	12/24/2000
M1215	Documentation of medical reason(s) for not documenting and	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	reviewing spirometry results (e.g., patients with dementia or	covered by the Plan. Not subject to pre-		
M1216	tracheostomy)	service review.  Non Covered: Procedure/service not	1 /1 /2024	12/21/2000
IVI1216	No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed	· ·	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre- service review.		
M1217	with results documented during the encounter  Documentation of system reason(s) for not documenting and	Non Covered: Procedure/service not	1/1/2024	12/31/2999
IVITZI/	reviewing spirometry results (e.g., spirometry equipment not	covered by the Plan. Not subject to pre-	1/1/2024	12/31/2999
	available at the time of the encounter)	service review.		
M1218	Patient has copd symptoms (e.g., dyspnea, cough/sputum,	Non Covered: Procedure/service not	1/1/2024	12/31/2999
1411710	wheezing)	covered by the Plan. Not subject to pre-	1, 1, 2024	12/31/2333
	wheeling)	service review.		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1220	Dilated retinal eye exam with interpretation by an	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	ophthalmologist or optometrist or artificial intelligence (ai)	covered by the Plan. Not subject to pre-		
	interpretation documented and reviewed; with evidence of	service review.		
	retinopathy			
M1221	Dilated retinal eye exam with interpretation by an	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	ophthalmologist or optometrist or artificial intelligence (ai)	covered by the Plan. Not subject to pre-		
	interpretation documented and reviewed; without evidence of retinopathy	service review.		
M1222	Glaucoma plan of care not documented, reason not otherwise	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	specified	covered by the Plan. Not subject to pre-		
		service review.		
M1223	Glaucoma plan of care documented	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1224	Intraocular pressure (iop) reduced by a value less than 20% from	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	the pre-intervention level	covered by the Plan. Not subject to pre-		
		service review.		
M1225	Intraocular pressure (iop) reduced by a value of greater than or	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	equal to 20% from the pre-intervention level	covered by the Plan. Not subject to pre-		
		service review.		
M1226	lop measurement not documented, reason not otherwise	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	specified	covered by the Plan. Not subject to pre-		
		service review.		
M1227	Evidence-based therapy was prescribed	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1228	Patient, who has a reactive hcv antibody test, and has a follow up		1/1/2024	12/31/2999
	hcv viral test that detected hcv viremia, has hcv treatment	covered by the Plan. Not subject to pre-		
	initiated within 3 months of the reactive hcv antibody test	service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1230	hcv infection  Patient has a reactive hcv antibody test and does not have a	Non Covered: Procedure/service not	1/1/2024	12/31/2999
IW123U	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	covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1231	Patient receives hcv antibody test with nonreactive result	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2024	12/31/2999
M1236	Baseline mrs > 2	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1238	Documentation that administration of second recombinant	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	zoster vaccine could not occur during the performance period	covered by the Plan. Not subject to pre-		
	due to the recommended 2-6 month interval between doses (i.e,	service review.		
	first dose received after october 31)			
M1239	Patient did not respond to the question of patient felt heard and	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	understood by this provider and team	covered by the Plan. Not subject to pre-		
		service review.		
M1240	Patient did not respond to the question of patient felt this	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	provider and team put my best interests first when making	covered by the Plan. Not subject to pre-		
	recommendations about my care	service review.		
M1241	Patient did not respond to the question of patient felt this	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	provider and team saw me as a person, not just someone with a	covered by the Plan. Not subject to pre-		
	medical problem	service review.		
M1242	Patient did not respond to the question of patient felt this	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	provider and team understood what is important to me in my life	covered by the Plan. Not subject to pre-		
		service review.		
M1243	Patient provided a response other than completely true for the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	question of patient felt heard and understood by this provider	covered by the Plan. Not subject to pre-		
	and team	service review.		
M1244	Patient provided a response other than completely true for the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	question of patient felt this provider and team put my best	covered by the Plan. Not subject to pre-		
	interests first when making recommendations about my care	service review.		
M1245	Patient provided a response other than completely true for the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	question of patient felt this provider and team saw me as a	covered by the Plan. Not subject to pre-		
	person, not just someone with a medical problem	service review.		
M1246	Patient provided a response other than completely true for the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	question of patient felt this provider and team understood what	covered by the Plan. Not subject to pre-		
	is important to me in my life	service review.		
M1247	Patient responded completely true for the question of patient	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	felt this provider and team put my best interests first when	covered by the Plan. Not subject to pre-		
	making recommendations about my care	service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1248	Patient responded completely true for the question of patient	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	felt this provider and team saw me as a person, not just someone	covered by the Plan. Not subject to pre-		
	with a medical problem	service review.		
M1249	Patient responded completely true for the question of patient	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	felt this provider and team understood what is important to me	covered by the Plan. Not subject to pre-		
	in my life	service review.		
M1250	Patient responded as completely true for the question of patient	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	felt heard and understood by this provider and team	covered by the Plan. Not subject to pre-		
		service review.		
M1251	Patients for whom a proxy completed the entire hu survey on	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	their behalf for any reason (no patient involvement)	covered by the Plan. Not subject to pre-		
		service review.		
M1252	Patients who did not complete at least one of the four patient	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	experience hu survey items and return the hu survey within 60	covered by the Plan. Not subject to pre-		
	days of the ambulatory palliative care visit	service review.		
M1253	Patients who respond on the patient experience hu survey that	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	they did not receive care by the listed ambulatory palliative care	covered by the Plan. Not subject to pre-		
	provider in the last 60 days (disavowal)	service review.		
M1254	Patients who were deceased when the hu survey reached them	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1255	Patients who have another reason for visiting the clinic [not	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
	but have not established the clinic as an ob provider (e.g., plan to	service review.		
	terminate the pregnancy or seek prenatal services elsewhere)			
M1256	Prior history of known cvd	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1257	Cvd risk assessment not performed or incomplete (e.g., cvd risk	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	assessment was not documented), reason not otherwise	covered by the Plan. Not subject to pre-		
	specified	service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1258	Cvd risk assessment performed, have a documented calculated	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	risk score	covered by the Plan. Not subject to pre-		
		service review.		
M1259	Patient status documented within the first year of initiating	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	dialysis	covered by the Plan. Not subject to pre-		
		service review.		
M1260	Patient status not documented within the first year of initiating	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	dialysis	covered by the Plan. Not subject to pre-		
		service review.		
M1261	Patients that were on the kidney or kidney-pancreas waitlist prior	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	to initiation of dialysis	covered by the Plan. Not subject to pre-		
		service review.		
M1262	Patients who had a transplant prior to initiation of dialysis	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1263	Patients in hospice on their initiation of dialysis date or during	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	the month of evaluation	covered by the Plan. Not subject to pre-		
		service review.		
M1265	Cms medical evidence form 2728 for dialysis patients: initial form		1/1/2024	12/31/2999
	completed	covered by the Plan. Not subject to pre-		
		service review.		
M1266	Patients admitted to a skilled nursing facility (snf)	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1267	Patients not observed in active status on any kidney or kidney-	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	pancreas transplant waitlist as of the last day of each month	covered by the Plan. Not subject to pre-		
	during the measurement period	service review.		
M1268	Patients observed in active status on any kidney or kidney-	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	pancreas transplant waitlist as of the last day of each month	covered by the Plan. Not subject to pre-		
	during the measurement period	service review.		
M1269	Receiving esrd mcp dialysis services by the provider on the last	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	day of the reporting month	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1270	Patients not on any kidney or kidney-pancreas transplant waitlist	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	as of the last day of each month during the measurement period	covered by the Plan. Not subject to pre-		
		service review.		
M1271	Patients with dementia at any time prior to or during the month	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1272	Patients observed on any kidney or kidney-pancreas transplant	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	waitlist as of the last day of each month during the measurement	covered by the Plan. Not subject to pre-		
	period	service review.		
M1273	Patients who were admitted to a skilled nursing facility (snf)	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	within one year of dialysis initiation according to the cms-2728	covered by the Plan. Not subject to pre-		
	form	service review.		
M1274	Patients who were admitted to a skilled nursing facility (snf)	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	during the month of evaluation were excluded from that month	covered by the Plan. Not subject to pre-		
		service review.		
M1275	Patients determined to be in hospice were excluded from month	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	of evaluation and the remainder of reporting period	covered by the Plan. Not subject to pre-		
		service review.		
M1276	Bmi documented outside normal parameters, no follow-up plan	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	documented, no reason given	covered by the Plan. Not subject to pre-		
		service review.		
M1277	Colorectal cancer screening results documented and reviewed	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1278	Elevated or hypertensive blood pressure reading documented,	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	and the indicated follow-up is documented	covered by the Plan. Not subject to pre-		
		service review.		
M1279	Elevated or hypertensive blood pressure reading documented,	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	indicated follow-up not documented, reason not given	covered by the Plan. Not subject to pre-		
		service review.		
M1280	Women who had a bilateral mastectomy or who have a history	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	of a bilateral mastectomy or for whom there is evidence of a	covered by the Plan. Not subject to pre-		
	right and a left unilateral mastectomy	service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1281	Blood pressure reading not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1282	Patient screened for tobacco use and identified as a tobacco non- user	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1283	Patient screened for tobacco use and identified as a tobacco user	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 consecutive days during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1285	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1286	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 preservice review.	1/1/2024	12/31/2999
M1287	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 preservice 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 preservice review.	1/1/2024	12/31/2999
M1289	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1290	Patient not eligible due to active diagnosis of hypertension	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1291	Patients 66 years of age and older with at least one	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	claim/encounter for frailty during the measurement period and a	covered by the Plan. Not subject to pre-		
	dispensed medication for dementia during the measurement	service review.		
	period or the year prior to the measurement period			
M1292	Patients 66 years of age and older with at least one	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	claim/encounter for frailty during the measurement period and	covered by the Plan. Not subject to pre-		
	an advanced illness diagnosis during the measurement period or	service review.		
	the year prior to the measurement period			
M1293	Bmi is documented above normal parameters and a follow-up	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	plan is documented	covered by the Plan. Not subject to pre-		
		service review.		
M1294	Normal blood pressure reading documented, follow-up not	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	required	covered by the Plan. Not subject to pre-		
		service review.		
M1295	Patients with a diagnosis or past history of total colectomy or	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	colorectal cancer	covered by the Plan. Not subject to pre-		
		service review.		
M1296	Bmi is documented within normal parameters and no follow-up	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	plan is required	covered by the Plan. Not subject to pre-		
		service review.		
M1297	Bmi not documented due to medical reason or patient refusal of	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	height or weight measurement	covered by the Plan. Not subject to pre-		
		service review.		
M1298	Documentation of patient pregnancy anytime during the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	measurement period prior to and including the current	covered by the Plan. Not subject to pre-		
	encounter	service review.		
M1299	Influenza immunization administered or previously received	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1300	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	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
	available or other system reasons)			
M1301	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1302	Screening, diagnostic, film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1303	Hospice services provided to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1304	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1305	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1306	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 preservice review.	1/1/2024	12/31/2999
M1307	Documentation stating the patient has received or is currently receiving palliative or hospice care	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1308	Influenza immunization was not administered, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1309	Palliative care services provided to patient any time during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1310	intervention during the measurement period or in the six months	·	1/1/2024	12/31/2999
M1311	Anaphylaxis due to the vaccine on or before the date of the encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1312	Patient not screened for tobacco use	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1313	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1314	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1315	Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1316	Current tobacco non-user	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1317	Patients who are counseled on connection with a csp and explicitly opt out	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1318	Patients who did not have documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening or documentation that there was no contact with a csp	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1319	Patients who had documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1320	Patients who screened positive for at least 1 of the 5 hrsns	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1321	Patients who were not seen within 7 weeks following the date of injection for follow up or who did not have a documented iop or no plan of care documented if the iop was >25 mm hg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1322	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop =<25 mm hg for injected eye	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1323	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop >25 mm hg and a plan of care was documented	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1324	Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1325		Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1326	Patients with a diagnosis of hypotony	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1327	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 8 weeks	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1328	Patients with a diagnosis of acute vitreous hemorrhage	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1329	Patients with a post-operative encounter of the eye with the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	acute pvd within 2 weeks before the initial encounter or 8 weeks	covered by the Plan. Not subject to pre-		
	after initial acute pvd encounter	service review.		
M1330	Documentation of patient reason(s) for not having a follow up	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	exam (e.g., inadequate time for follow up)	covered by the Plan. Not subject to pre-		
		service review.		
M1331	Patients who were appropriately evaluated during the initial	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	exam and were re-evaluated no later than 8 weeks from initial	covered by the Plan. Not subject to pre-		
	exam	service review.		
M1332	Patients who were not appropriately evaluated during the initial	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	exam and/or who were not re-evaluated within 2 weeks	covered by the Plan. Not subject to pre-		
		service review.		
M1333	Acute vitreous hemorrhage	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1334	Patients with a post-operative encounter of the eye with the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	acute pvd within 2 weeks before the initial encounter or 2 weeks	covered by the Plan. Not subject to pre-		
	after initial acute pvd encounter	service review.		
M1335	Documentation of patient reason(s) for not having a follow up	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	exam (e.g., inadequate time for follow up)	covered by the Plan. Not subject to pre-		
		service review.		
M1336	Patients who were appropriately evaluated during the initial	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	exam and were re-evaluated no later than 2 weeks	covered by the Plan. Not subject to pre-		
		service review.		
M1337	Acute pvd	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1338	Patients who had follow-up assessment 30 to 180 days after the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	index assessment who did not demonstrate positive	covered by the Plan. Not subject to pre-		
	improvement or maintenance of functioning scores during the	service review.		
	performance period			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1339	Patients who had follow-up assessment 30 to 180 days after the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	index assessment who demonstrated positive improvement or	covered by the Plan. Not subject to pre-		
	maintenance of functioning scores during the performance	service review.		
	period			
M1340	Index assessment completed using the 12-item whodas 2.0 or sds	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	during the denominator identification period	covered by the Plan. Not subject to pre-		
		service review.		
M1341	Patients who did not have a follow-up assessment or did not	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	have an assessment within 30 to 180 days after the index	covered by the Plan. Not subject to pre-		
	assessment during the performance period	service review.		
M1342	Patients who died during the performance period	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1343	Patients who are at pam level 4 at baseline or patients who are	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	flagged with extreme straight line response sets on the pam or	covered by the Plan. Not subject to pre-		
	with excessive missing responses	service review.		
M1344	Patients who did not have a baseline pam score and/or a second	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	score within 4 to 12 months of baseline pam score	covered by the Plan. Not subject to pre-		
		service review.		
M1345	Patients who had a baseline pam score and a second score within	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	4 to 12 month of baseline pam score	covered by the Plan. Not subject to pre-		
		service review.		
M1346	Patients who did not have a net increase in pam score of at least	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	6 points within a 4 to 12 month period	covered by the Plan. Not subject to pre-		
		service review.		
M1347	Patients who achieved a net increase in pam score of at least 3	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	points in a 4 to 12 month period (passing)	covered by the Plan. Not subject to pre-		
		service review.		
M1348	Patients who achieved a net increase in pam score of at least 6-	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	points in a 4 to 12 month period (excellent)	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1349	Patients who did not have a net increase in pam score of at least 3 points within a 4 to 12 month period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1350	Patients who had a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1351	Patients who had a suicide safety plan initiated, reviewed, or updated and reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1352	Suicidal ideation and/or behavior symptoms based on the c-ssrs or equivalent assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1353	Patients who did not have a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1354	Patients who did not have a suicide safety plan initiated, reviewed, or updated or reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1355	Suicide risk based on their clinician's evaluation or a clinician- rated tool	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1356	Patients who died during the measurement period	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999
M1357	Patients who had a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
M1358	Patients who did not have a reduction in suicidal ideation and/or	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	behavior upon follow-up assessment within 120 days of index	covered by the Plan. Not subject to pre-		
	assessment	service review.		
M1359	Index assessment during the denominator period when the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	suicidal ideation and/or behavior symptoms or increased suicide	covered by the Plan. Not subject to pre-		
	risk by clinician determination occurs and a non-zero c-ssrs score	service review.		
	is obtained			
M1360	Suicidal ideation and/or behavior symptoms based on the c-ssrs	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1361	Suicide risk based on their clinician's evaluation or a clinician-	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	rated tool	covered by the Plan. Not subject to pre-		
		service review.		
M1362	Patients who died during the measurement period	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1363	Patients who did not have a follow-up assessment within 120	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	days of the index assessment	covered by the Plan. Not subject to pre-		
		service review.		
M1364	Calculated 10-year ascvd risk score of >= 20 percent during the	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	performance period	covered by the Plan. Not subject to pre-		
		service review.		
M1365	Patient encounter during the performance period with hospice	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	and palliative care specialty code 17	covered by the Plan. Not subject to pre-		
		service review.		
M1366	Focusing on women's health mips value pathway	Non Covered: Procedure/service not	1/1/2024	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
M1367	Quality care for the treatment of ear, nose, and throat disorders	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	mips value pathway	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
M1368	Prevention and treatment of infectious disorders including	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	hepatitis c and hiv mips value pathway	covered by the Plan. Not subject to pre-		
		service review.		
M1369	Quality care in mental health and substance use disorders mips	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	value pathway	covered by the Plan. Not subject to pre-		
		service review.		
M1370	Rehabilitative support for musculoskeletal care mips value	Non Covered: Procedure/service not	1/1/2024	12/31/2999
	pathway	covered by the Plan. Not subject to pre-		
		service review.		
P2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed	9/24/2012	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
P9020	Platelet rich plasma, each unit	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q0035	Cardiokymography	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
Q0114	Fern test	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	mucous	covered by the Plan. Not subject to pre-		
		service review.		
Q0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed	6/1/2023	1/31/2025
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed	6/1/2023	1/31/2025
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed	6/1/2023	1/31/2025
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed	6/1/2023	3/31/2025
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q0477	Power module patient cable for use with electric or	MP Criteria: Procedure/service reviewed	1/1/2018	12/31/2999
	electric/pneumatic ventricular assist device, replacement only	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q0478	Power adapter for use with electric or electric/pneumatic	MP Criteria: Procedure/service reviewed	1/1/2011	12/31/2999
	ventricular assist device, vehicle type	against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q0479	Power module for use with electric or electric/pneumatic	MP Criteria: Procedure/service reviewed	1/1/2011	12/31/2999
•	ventricular assist device, replacement only	against Medical Policy Criteria. Submit	` '	
	,	for Recommended Clinical Review to		
		avoid post-service review.		
		,		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
Q0480	Driver for use with 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
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
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 Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0496	Battery, other than lithium-ion, 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
Q0497	Battery clips 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
Q0498	Holster 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
Q0499	Belt/vest/bag for use to carry external peripheral components of any type 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
Q0500	Filters 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
Q0501	Shower cover 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
Q0502	Mobility cart for 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
Q0503	Battery for pneumatic ventricular assist device, replacement only, each	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	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
Q0506	Battery, lithium-ion, 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.	1/1/2010	12/31/2999
Q0507	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2013	12/31/2999
Q0511	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI- EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	11/1/2024	12/31/2999
Q0521	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2025	12/31/2999
Q2026	INJECTION, RADIESSE, 0.1 ML	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
Q2028	Injection, sculptra, 0.5 mg	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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2018	12/31/2999
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2024	12/31/2999
Q2052	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2014	12/31/2999
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti- cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti- cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	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
Q2055		MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
Q2056		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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2007	12/31/2999
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4103	OASIS BURN 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
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), 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
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4110	PRIMATRIX, 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
Q4111	GAMMAGRAFT, 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
Q4112	CYMETRA, INJECTABLE, 1CC	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	2/1/2021	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed	2/1/2021	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4121	THERASKIN, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed	7/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square	MP Criteria: Procedure/service reviewed	10/15/2021	12/31/2999
	centimeter	against Medical Policy Criteria. Submit		, , , , , , , , , , , , , , , , , , ,
		for Recommended Clinical Review to		
		avoid post-service review.		
		·		
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	CENTIMETER	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	•	5/15/2021	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4127	TALYMED, 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
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4130	STRATTICE TM, 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
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4134	Hmatrix, 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

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4135	Mediskin, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4136	Ez-derm, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	MP Criteria: Procedure/service reviewed	8/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
	square centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	centimeter	by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	8/1/2018	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed	8/1/2018	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed	2/1/2022	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	8/1/2018	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
04171	Interful 1 mg	(CPCP).	12/1/2020	12/21/2000
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU 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	12/1/2020	12/31/2999
		by the Plan. 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	4/1/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4186	Epifix, per square centimeter	MP Criteria: Procedure/service reviewed	7/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed	7/1/2020	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4197	Puraply xt, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4212	Allogen, per cc	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4213	Ascent, 0.5 mg	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4216	Artacent cord, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
	Xplus or BioWound Xplus, per square centimeter	by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	5/15/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
	centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4225	Amniobind or dermabind tl, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4226	MyOwn skin, includes harvesting and preparation procedures,	EIU: Procedure/service not reimbursed	10/1/2024	12/31/2999
	per square centimeter	by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed	12/1/2020	3/31/2025
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4237	Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	12/1/2020	12/31/2999
		by the Plan. 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	3/1/2021	12/31/2999
		by the Plan. 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	3/1/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. 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	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed	4/15/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4254	Novafix dl, per square centimeter	EIU: Procedure/service not reimbursed	3/1/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed	3/1/2021	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2022	12/31/2999
		by the Plan. 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	EIU: Procedure/service not reimbursed	1/1/2023	12/31/2999
	centimeter	by the Plan. 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	1/1/2023	12/31/2999
		by the Plan. 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	1/1/2023	12/31/2999
		by the Plan. 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	1/1/2023	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4263	Surgraft tl, per square centimeter	MP Criteria: Procedure/service reviewed	1/1/2023	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4264	Cocoon membrane, per square centimeter	MP Criteria: Procedure/service reviewed	1/1/2023	12/31/2999
		against Medical Policy Criteria. Submit	' '	
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. 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	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. 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	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed	9/1/2023	12/31/2999
		by the Plan. 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	9/1/2023	12/31/2999
		by the Plan. 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	12/1/2023	12/31/2999
		by the Plan. 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	12/1/2023	12/31/2999
		by the Plan. 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	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. 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	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4282	Cygnus dual, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4283	Biovance tri-layer or biovance 3I, per square centimeter	MP Criteria: Procedure/service reviewed	7/15/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4283	Biovance tri-layer or biovance 3l, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed	12/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	EIU: Procedure/service not reimbursed	10/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
04286	Nicolary of an acceleration of the second continuation	(CPCP).	10/1/2022	12/21/2000
Q4286	Nudyn sl or nudyn slw, per square centimeter	EIU: Procedure/service not reimbursed	10/1/2023	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy (CPCP).		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4287	Dermabind dl, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4304	Grafix plus, per square centimeter	MP Criteria: Procedure/service reviewed	1/1/2024	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed	4/1/2024	12/31/2999
		by the Plan. 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	4/1/2024	12/31/2999
		by the Plan. 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	4/1/2024	12/31/2999
		by the Plan. 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	4/1/2024	12/31/2999
		by the Plan. 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	4/1/2024	12/31/2999
		by the Plan. 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	4/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4314	Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4317	Vitograft, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4328	Most, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. 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	7/1/2024	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4334	Amnioplast 1, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4334	Amnioplast 1, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4335	Amnioplast 2, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4335	Amnioplast 2, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4336	Artacent c, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4336	Artacent c, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4337	Artacent trident, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
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Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4337	Artacent trident, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4338	Artacent velos, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4338	Artacent velos, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4339	Artacent vericlen, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		
Q4339	Artacent vericlen, per square centimeter	EIU: Procedure/service not reimbursed	5/15/2025	12/31/2999
		by the Plan. Not subject to pre-service		
		review. Check EIU policy, which is one of		
		our Clinical Payment and Coding Policy		
		(CPCP).		
Q4340	Simpligraft, per square centimeter	MP Criteria: Procedure/service reviewed	10/1/2024	5/14/2025
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4340	Simpligraft, 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).	5/15/2025	12/31/2999
Q4341	Simplimax, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4341	Simplimax, 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).	5/15/2025	12/31/2999
Q4342	Theramend, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4342	Theramend, 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).	5/15/2025	12/31/2999
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
Q4343	Dermacyte ac matrix amniotic membrane allograft, 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).	5/15/2025	12/31/2999
Q4344	Tri-membrane wrap, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4344	Tri-membrane wrap, 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).	5/15/2025	12/31/2999
Q4345	Matrix hd allograft dermis, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4345	Matrix hd allograft dermis, 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).	5/15/2025	12/31/2999
Q4346	Shelter dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4347	Rampart dl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q4348	Sentry sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q4349	Mantle dl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q4350	Palisade dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q4351	Enclose tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q4352	Overlay sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q4353	Xceed tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	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
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	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
Q5128	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	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
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	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
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	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
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
Q5139	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	3/31/2025
Q9004	Department of veterans affairs whole health partner services	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2021	12/31/2999
Q9982	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	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
Q9983	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	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
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
S0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
S0122	Injection, menotropins, 75 iu	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0126	Injection, follitropin alfa, 75 iu	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0128	Injection, follitropin beta, 75 iu	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0155	Sterile dilutant for epoprostenol, 50ml	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
S0157	Becaplermin gel 0. 01%, 0. 5 gm	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S0189	Testosterone pellet, 75mg	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
S0194	DIALYSIS/STRESS VITAMIN SUPPLEMENT, ORAL100 CAPSULES	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0197	PRENATAL VITAMINS, 30-DAY SUPPLY	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	4/1/2005	12/31/2999
S0207	Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0209	Wheelchair van, mileage, per mile	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
S0257	COUNSELING AND DISCUSSION REGARDING ADVANCE DIRECTIVES OR END OF LIFE CARE PLANNING AND DECISIONS, WITH PATIENT AND/OR SURROGATE (LIST SEPARATELY IN ADDITION TO CODE FOR APPROPRIATE EVALUATION AND MANAGEMENT SERVICE)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
S0315	Disease management program; initial assessment and initiation of the program	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0316	DISEASE MANAGEMENT PROGRAM; FOLLOW-UP/REASSESSMENT	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0317	Disease management program; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0390	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e. G. Diabetes), per visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
S0510	Non-prescription lens (safety, athletic, or sunglass), per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0514	Color contact lens, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0516	Safety eyeglass frames	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0518	Sunglasses frames	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0596	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2012	12/31/2999
S0622	Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S0800	Laser in situ keratomileusis (lasik)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2021	12/31/2999
S0812	Phototherapeutic keratectomy (ptk)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
S1030	Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use cpt code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2009	12/31/2999
S1031	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use cpt code)	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
S1034	Artificial pancreas device system (eg, low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1035	Sensor; invasive (eg, subcutaneous), disposable, for use with artificial pancreas device system, 1 unit = 1 day supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1036	Transmitter; external, for use with artificial pancreas device system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
S1037	Receiver (monitor); external, for use with artificial pancreas device system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1040	CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT(S)	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
S1091	Stent, non-coronary, temporary, with delivery system (propel)	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
S2080	Laser-assisted uvulopalatoplasty (laup)	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
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2004	12/31/2999
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S2102	Islet cell tissue transplant from pancreas; allogeneic	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
S2103	Adrenal tissue transplant to brain	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
S2107	Adoptive immunotherapy i. E. Development of specific anti- tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	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
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	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
S2117	Arthroereisis, subtalar	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
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S2140	Cord blood harvesting for transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2142	Cord blood-derived stem-cell transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, 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	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
S2202	Echosclerotherapy	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
S2230	Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2003	12/31/2999
S2235	Implantation of auditory brain stem implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2003	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	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
S2348	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, USING RADIOFREQUENCY ENERGY, SINGLE OR MULTIPLE LEVELS, LUMBAR	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
S2400	Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	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
S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero	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
S2402	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	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
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero	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
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	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
S2409	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	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
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	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
S3650	Saliva test, hormone level; during menopause	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
S3652	Saliva test, hormone level; to assess preterm labor risk	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
\$3655	Antisperm antibodies test (immunobead)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
S3722	DOSE OPTIMIZATION BY AREA UNDER THE CURVE (AUC) ANALYSIS, FOR INFUSIONAL 5-FLUOROURACIL	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
\$3900	Surface electromyography (emg)	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
S4005	Interim labor facility global (labor occurring but not resulting in delivery)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4011	In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4013	Complete cycle, gamete intrafallopian transfer (gift), case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4014	Complete cycle, zygote intrafallopian transfer (zift), case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4015	Complete in vitro fertilization cycle, not otherwise specified, case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4016	Frozen in vitro fertilization cycle, case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S4018	Frozen embryo transfer procedure cancelled before transfer,	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	case rate	covered by the Plan. Not subject to pre-		
		service review.		
S4020	In vitro fertilization procedure cancelled before aspiration, case	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	rate	covered by the Plan. Not subject to pre-		
		service review.		
S4021	In vitro fertilization procedure cancelled after aspiration, case	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	rate	covered by the Plan. Not subject to pre-		
		service review.		
S4022	Assisted oocyte fertilization, case rate	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4023	Donor egg cycle, incomplete, case rate	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4025	Donor services for in vitro fertilization (sperm or embryo), case	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	rate	covered by the Plan. Not subject to pre-		
		service review.		
S4026	Procurement of donor sperm from sperm bank	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4027	Storage of previously frozen embryos	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4028	Microsurgical epididymal sperm aspiration (mesa)	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4030	Sperm procurement and cryopreservation services; initial visit	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S4031	Sperm procurement and cryopreservation services; subsequent	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	visit	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S4035	Stimulated intrauterine insemination (iui), case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4037	Cryopreserved embryo transfer, case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4042	MANAGEMENT OF OVULATION INDUCTION (INTERPRETATION OF DIAGNOSTIC TESTS AND STUDIES, NON-FACE-TO-FACE MEDICAL MANAGEMENT OF THE PATIENT), PER CYCLE	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
S4988	Penile contracture device, manual, greater than 3 lbs traction force	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	3/31/2025
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
\$5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S5101	Day care services, adult; per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S5102	Day care services, adult; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5105	Day care services, center-based; services not included in program	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	fee, per diem	covered by the Plan. Not subject to pre-		
		service review.		
S5108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5109	Home care training to home care client, per session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5110	Home care training, family; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5111	Home care training, family; per session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5116	Home care training, non-family; per session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5120	Chore services; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5121	Chore services; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
S5126	Attendant care services; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5135	Companion care, adult (e. G. ladl/adl); per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5136	Companion care, adult (e. G. ladl/adl); per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5140	Foster care, adult; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5141	Foster care, adult; per month	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	Ending Date
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5161	Emergency response system; service fee, per month (excludes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	installation and testing)	covered by the Plan. Not subject to pre-		
		service review.		
S5162	Emergency response system; purchase only	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5165	Home modifications; per service	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S5199	Personal care item, nos, each	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed	4/1/2009	12/31/2999
		against Medical Policy Criteria. Submit		
		for Recommended Clinical Review to		
		avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
\$8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2006	12/31/2999
S8080	Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical	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
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	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
58131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	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
S8185	Flutter device	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
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	7/1/2005	12/31/2999
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	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

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S8940	EQUESTRIAN/HIPPOTHERAPY, PER SESSION	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
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 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
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	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
S9001	Home uterine monitor with or without associated nursing services	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
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	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
S9055	Procuren or other growth factor preparation to promote wound healing	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S9056	Coma stimulation per diem	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
S9090	Vertebral axial decompression, per session	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
S9117	Back school, per visit	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
S9125	Respite care, in the home, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	3/1/2008	12/31/2999
S9145	Insulin pump initiation, instruction in initial use of pump (pump not included)	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
S9335	Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem	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
S9340	Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula 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.	9/14/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
S9341	Home therapy; enteral nutrition via gravity; administrative	MP Criteria: Procedure/service reviewed	9/14/2009	12/31/2999
	services, professional pharmacy services, care coordination, and	against Medical Policy Criteria. Submit		
	all necessary supplies and equipment (enteral formula and	for Recommended Clinical Review to		
	nursing visits coded separately), per diem	avoid post-service review.		
S9342	Home therapy; enteral nutrition via pump; administrative	MP Criteria: Procedure/service reviewed	9/14/2009	12/31/2999
	services, professional pharmacy services, care coordination, and	against Medical Policy Criteria. Submit		
	all necessary supplies and equipment (enteral formula and	for Recommended Clinical Review to		
	nursing visits coded separately), per diem	avoid post-service review.		
S9343	Home therapy; enteral nutrition via bolus; administrative	MP Criteria: Procedure/service reviewed	7/27/2009	12/31/2999
	services, professional pharmacy services, care coordination, and	against Medical Policy Criteria. Submit		
	all necessary supplies and equipment (enteral formula and	for Recommended Clinical Review to		
	nursing visits coded separately), per diem	avoid post-service review.		
S9355	Home infusion therapy, chelation therapy; administrative	MP Criteria: Procedure/service reviewed	10/15/2007	12/31/2999
	services, professional pharmacy services, care coordination, and	against Medical Policy Criteria. Submit		
	all necessary supplies and equipment (drugs and nursing visits	for Recommended Clinical Review to		
	coded separately), per diem	avoid post-service review.		
S9364	Home infusion therapy, total parenteral nutrition (tpn);	MP Criteria: Procedure/service reviewed	9/14/2009	12/31/2999
	administrative services, professional pharmacy services, care	against Medical Policy Criteria. Submit		
	coordination, and all necessary supplies and equipment including	for Recommended Clinical Review to		
	standard tpn formula (lipids, specialty amino acid formulas, drugs	avoid post-service review.		
	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)			

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S9366	Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula 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.	9/14/2009	12/31/2999
S9367	Home infusion therapy, total parenteral nutrition (tpn); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	•	9/14/2009	12/31/2999
S9368	Home infusion therapy, total parenteral nutrition (tpn); more than three liters per day, administrative services, professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/14/2009	12/31/2999
S9381	,	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9401	tests, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9430	Pharmacy compounding and dispensing services	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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S9432	Medical foods for non-inborn errors of metabolism	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2021	12/31/2999
S9434	Modified solid food supplements for inborn errors of metabolism	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
\$9435	Medical foods for inborn errors of metabolism	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
S9436	Childbirth preparation/lamaze classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9437	Childbirth refresher classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9438	Cesarean birth classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9439	Vbac (vaginal birth after cesarean) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9441	Asthma education, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9442	Birthing classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9444	Parenting classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9446	Patient education, not otherwise classified, non-physician provider, group, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
S9447	Infant safety (including cpr) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice 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 preservice 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 preservice 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 preservice 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 preservice review.	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
S9537	Home therapy; hematopoietic hormone injection therapy (e. G. Erythropoietin, g-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.		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
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 preservice 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

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
S9970	Health club membership, annual	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9976	Lodging, per diem, not otherwise classified	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9977	Meals, per diem, not otherwise specified	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9981	Medical records copying fee, administrative	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9982	Medical records copying fee, per page	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9986	Not medically necessary service (patient is aware that service not	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	medically necessary)	covered by the Plan. Not subject to pre-		
		service review.		
S9988	Services provided as part of a phase i clinical trial	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9989	Services provided outside of the united states of america (list in	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	addition to code(s) for services(s))	covered by the Plan. Not subject to pre-		
		service review.		
S9990	Services provided as part of a phase ii clinical trial	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9991	Services provided as part of a phase iii clinical trial	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9992	Transportation costs to and from trial location and local	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	transportation costs (e. G. , fares for taxicab or bus) for clinical	covered by the Plan. Not subject to pre-		
	trial participant and one caregiver/companion	service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
S9994	Lodging costs (e. G., hotel charges) for clinical trial participant	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	and one caregiver/companion	covered by the Plan. Not subject to pre-		
		service review.		
S9996	Meals for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
S9999	Sales tax	Non Covered: Procedure/service not	6/1/2014	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T1005	Respite care services, up to 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T1006	Alcohol and/or substance abuse services, family/couple	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	counseling	covered by the Plan. Not subject to pre-		
		service review.		
T1009	Child sitting services for children of the individual receiving	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	alcohol and/or substance abuse services	covered by the Plan. Not subject to pre-		
		service review.		
T1010	Meals for individuals receiving alcohol and/or substance abuse	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	services (when meals not included in the program)	covered by the Plan. Not subject to pre-		
		service review.		
T1012	Alcohol and/or substance abuse services, skills development	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T1013	Sign language or oral interpretive services, per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T1014	Telehealth transmission, per minute, professional services bill	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	separately	covered by the Plan. Not subject to pre-		
		service review.		
T1018	School-based individualized education program (iep) services,	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	bundled	covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T1029	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T1032	Services performed by a doula birth worker, per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2022	12/31/2999
T1033	Services performed by a doula birth worker, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	10/1/2022	12/31/2999
T2001	Non-emergency transportation; patient attendant/escort	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T2002	Non-emergency transportation; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T2003	Non-emergency transportation; encounter/trip	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T2004	Non-emergency transport; commercial carrier, multi-pass	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T2005	Non-emergency transportation; stretcher van	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
T2012	Habilitation, educational; waiver, per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2013	Habilitation, educational, waiver; per hour	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2014	Habilitation, prevocational, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2015	Habilitation, prevocational, waiver; per hour	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2016	Habilitation, residential, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2017	Habilitation, residential, waiver; 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2018	Habilitation, supported employment, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2019	Habilitation, supported employment, waiver; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2020	Day habilitation, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2021	Day habilitation, waiver; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2026	Specialized childcare, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
T2027	Specialized childcare, waiver; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2028	Specialized supply, not otherwise specified, waiver	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2029	Specialized medical equipment, not otherwise specified, waiver	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2034	Crisis intervention, waiver; per diem	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2035	Utility services to support medical equipment and assistive	Non Covered: Procedure/service not	1/1/1950	12/31/2999
	technology/devices, waiver	covered by the Plan. Not subject to pre-		
		service review.		
T2036	Therapeutic camping, overnight, waiver; each session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2037	Therapeutic camping, day, waiver; each session	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2038	Community transition, waiver; per service	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2039	Vehicle modifications, waiver; per service	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2040	Financial management, self-directed, waiver; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		
T2041	Supports brokerage, self-directed, waiver; per 15 minutes	Non Covered: Procedure/service not	1/1/1950	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
NON-EMERGENCY TRANSPORTATION; STRETCHER VAN,	Non Covered: Procedure/service not	7/1/2004	12/31/2999
MILEAGE; PER MILE	covered by the Plan. Not subject to pre-		
	service review.		
Financial management, self-directed, waiver; per diem	Non Covered: Procedure/service not	4/1/2022	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Supports brokerage, self-directed, waiver; per diem	Non Covered: Procedure/service not	4/1/2022	12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
Human breast milk processing, storage and distribution only	·		12/31/2999
	covered by the Plan. Not subject to pre-		
	service review.		
	· ·	1/1/2005	12/31/2999
BRIEF/DIAPER, SMALL, EACH	,		
	•	1/1/2005	12/31/2999
BRIEF/DIAPER, MEDIUM, EACH			
	· ·	1/1/2005	12/31/2999
BRIEF/DIAPER, LARGE, EACH			
ADJULT SIZED DISDOCADIE INCONTINUENCE DDODLIGT		4 /4 /2025	12/24/2000
	· ·	1/1/2005	12/31/2999
BRIEF/DIAPER, EXTRA LARGE, EACH			
ADULT CIZED DICDOCADLE INCONTINENCE PRODUCT		1 /1 /2005	12/21/2000
, and the second	·	1/1/2005	12/31/2999
FROTECTIVE UNDERWEAR/FULL-ON, SWALL SIZE, EACH	,		
ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT		1/1/2005	12/31/2999
	•	1/1/2003	12/31/2333
THE PERIOD STATE OF THE STATE O			
ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT.		1/1/2005	12/31/2999
	•	, =, =====	_, -, -, -, -, -, -, -, -, -, -, -, -, -,
	NON-EMERGENCY TRANSPORTATION; STRETCHER VAN, MILEAGE; PER MILE  Financial management, self-directed, waiver; per diem	NON-EMERGENCY TRANSPORTATION; STRETCHER VAN, MILEAGE; PER MILE  Financial management, self-directed, waiver; per diem  Financial management, self-directed, waiver; per diem  Supports brokerage, self-directed, waiver; per diem  Supports brokerage, self-directed, waiver; per diem  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Human breast milk processing, storage and distribution only  Human breast milk processing, storage and distribution only  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  ADULT SIZED DISPOSABLE INCO	NON-EMERGENCY TRANSPORTATION; STRETCHER VAN, MILEAGE; PER MILE  Financial management, self-directed, waiver; per diem  Financial management, self-directed, waiver; per diem  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Supports brokerage, self-directed, waiver; per diem  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  Human breast milk processing, storage and distribution only  Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH  ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH

Procedure Code	Code Description	Code Group & Description	Effective Date	<b>Ending Date</b>
T4528	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	BRIEF/DIAPER, LARGE SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4531	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE,	covered by the Plan. Not subject to pre-		
	EACH	service review.		
T4532	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	BRIEF/DIAPER, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4534	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	PROTECTIVE UNDERWEAR/PULL-ON, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	INCONTINENCE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4536	INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	REUSABLE, ANY SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4537	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE,	Non Covered: Procedure/service not	1/1/2005	12/31/2999
	BED SIZE, EACH	covered by the Plan. Not subject to pre-		
		service review.		
T4538	DIAPER SERVICE, REUSABLE DIAPER, EACH DIAPER	Non Covered: Procedure/service not	1/1/2005	12/31/2999
		covered by the Plan. Not subject to pre-		
		service review.		

<b>Procedure Code</b>	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
T4539	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUSABLE, ANY SIZE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
T4540	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
T4541	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
T4542	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, SMALL SIZE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
T4543	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2007	12/31/2999
T5001	POSITIONING SEAT FOR PERSONS WITH SPECIAL ORTHOPEDIC NEEDS	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2627	Scleral cover shell	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
V2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/2005	12/31/2999
V2745	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2756	Eye glass case	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
V2761	Mirror coating, any type, solid, gradient or equal, any lens material, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2762	Polarization, any lens material, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2782	Lens, index 1. 54 to 1. 65 plastic or 1. 60 to 1. 79 glass, excludes polycarbonate, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2783	Lens, index greater than or equal to 1. 66 plastic or greater than or equal to 1. 80 glass, excludes polycarbonate, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2790	Amniotic membrane for surgical reconstruction, per procedure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
V2797	Vision supply, accessory and/or service component of another hcpcs vision code	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	<b>Effective Date</b>	<b>Ending Date</b>
V5095	Semi-implantable middle ear hearing prosthesis	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
V5269	Assistive listening device, alerting, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V5270	Assistive listening device, television amplifier, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V5271	Assistive listening device, television caption decoder	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V5272	Assistive listening device, tdd	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V5273	Assistive listening device, for use with cochlear implant	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999
V5274	Assistive listening device, not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to preservice review.	1/1/1950	12/31/2999

Procedure Code Code Description Code Group & Description Effective Date Ending Date

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Please note that checking eligibility and benefits and/or the fact that a service has been prior authorized or has a recommended clinical review 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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