BlueCross BlueShield of Oklahoma

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

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| **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:**<br><br>**- Subject to a medical necessity review,**<br>**- Candidates for a Recommended Clinical Review,**<br>**- Not a benefit for our members,**<br>**- Considered experimental, investigational and unproven (EIU), or**<br>**- Not on our prior authorization list (with some exceptions based on members' benefit plans)**<br>**Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025.** | **Utilization Management Process**<br><br>**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 |
|---|---|
| Medical Policy Criteria (MP Criteria) | Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.<br><br>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. |
| Experimental, Investigational, Unproven (EIU) | Medical Policy Coverage statement indicates procedure/service is experimental, investigational, and/or unproven in all situations. |
| Unlisted or Undefined | 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 |
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| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 | Ending Date |
|---|---|---|---|---|
| 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 | Ending Date |
|---|---|---|---|---|
| 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 | Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin 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 |
| 15015 | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms legs; first 480 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 |
| 15016 | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms legs; 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 15017 | 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; first 480 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 |
| 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 | 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 |
| 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 |

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

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

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 15999 | Unlisted procedure, excision pressure ulcer | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | 8/31/2025 |
| 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 | 8/31/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 17999 | Unlisted procedure, skin, mucous membrane and subcutaneous tissue | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 19303 | Mastectomy, simple, complete | 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 |
| 19325 | Breast augmentation with implant | 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 |
| 19328 | Removal of intact breast implant | 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 | Ending Date |
|---|---|---|---|---|
| 19330 | Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel) | 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 |
| 19340 | Insertion of breast implant on same day of mastectomy (ie, immediate) | 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 |
| 19342 | Insertion or replacement of breast implant on separate day from mastectomy | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 19499 | Unlisted procedure, breast | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 20999 | Unlisted procedure, musculoskeletal system, general | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 21089 | Unlisted maxillofacial prosthetic procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |
| 21299 | Unlisted craniofacial and maxillofacial procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 21499 | Unlisted musculoskeletal procedure, head | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 | 9/30/2025 |
| 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 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 9/30/2025 |
| 21899 | Unlisted procedure, neck or thorax | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 |
| 22526 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single 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). | 1/1/2023 | 12/31/2999 |
| 22527 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (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). | 1/1/2023 | 12/31/2999 |
| 22586 | Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace | EIU: Procedure/service not reimbursed by the Plan. 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 | Ending Date |
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| 22836 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22837 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 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). | 5/15/2024 | 12/31/2999 |
| 22838 | Revision (eg, augmentation, division of tether), replacement, or removal of thoracic 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 |
| 22867 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single 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). | 1/1/2023 | 12/31/2999 |
| 22868 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second 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). | 1/1/2023 | 12/31/2999 |
| 22869 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single 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). | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 22870 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second 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). | 1/1/2023 | 12/31/2999 |
| 22899 | Unlisted procedure, spine | 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 |
| 22899 | Unlisted procedure, spine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 22999 | Unlisted procedure, abdomen, musculoskeletal system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 23929 | Unlisted procedure, shoulder | 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 |
| 23929 | Unlisted procedure, shoulder | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 24999 | Unlisted procedure, humerus or elbow | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 25999 | Unlisted procedure, forearm or wrist | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 26989 | Unlisted procedure, hands or fingers | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 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 |
| 27299 | Unlisted procedure, pelvis or hip joint | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 27599 | Unlisted procedure, femur or knee | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 |
| 27899 | Unlisted procedure, leg or ankle | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 28899 | Unlisted procedure, foot or toes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 29799 | Unlisted procedure, casting or strapping | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 | 3/31/2025 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 |
| 29999 | Unlisted procedure, arthroscopy | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 30140 | Submucous resection inferior turbinate, partial or complete, any method | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 30999 | Unlisted procedure, nose | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 31299 | Unlisted procedure, accessory sinuses | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 31599 | Unlisted procedure, larynx | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 31899 | Unlisted procedure, trachea, bronchi | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 32999 | Unlisted procedure, lungs and pleura | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 33274 | Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 33275 | Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2020 | 12/31/2999 |
| 33276 | Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33277 | Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33278 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33279 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 33280 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33281 | Repositioning of phrenic nerve stimulator transvenous lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33285 | Insertion, subcutaneous cardiac rhythm monitor, including programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| 33287 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33288 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) | EIU: Procedure/service not reimbursed by the Plan. 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 |
| 33289 | Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 33340 | Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, 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. | 1/1/2017 | 12/31/2999 |
| 33361 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach | 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 |
| 33362 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 33369 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (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 |
| 33370 | Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (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. | 2/15/2025 | 12/31/2999 |
| 33418 | Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 33419 | Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) 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. | 2/15/2016 | 12/31/2999 |
| 33477 | Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed | 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 |
| 33883 | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension | 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 |
| 33884 | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (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. | 1/1/2006 | 12/31/2999 |
| 33927 | Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy | 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 |
| 33928 | Removal and replacement of total replacement heart system (artificial heart) | 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 | Ending Date |
|---|---|---|---|---|
| 33929 | Removal of a total replacement heart system (artificial heart) for heart 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. | 1/1/2018 | 12/31/2999 |
| 33975 | Insertion of ventricular assist device; extracorporeal, 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 |
| 33976 | Insertion of ventricular assist device; extracorporeal, biventricular | 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 33999 | Unlisted procedure, cardiac surgery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 36299 | Unlisted procedure, vascular injection | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 36476 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | 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 | Ending Date |
|---|---|---|---|---|
| 36478 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 36479 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 36482 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019 | 12/31/2999 |
| 36483 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019 | 12/31/2999 |
| 36511 | Therapeutic apheresis; for white blood cells | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2003 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 36522 | Photopheresis, extracorporeal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/27/2009 | 12/31/2999 |
| 36563 | Insertion of tunneled centrally inserted central venous access device with subcutaneous pump | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2007 | 12/31/2999 |
| 36836 | Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 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 | EIU: Procedure/service not 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 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 37216 | Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 37217 | Transcatheter placement of intravascular stent(s), intrathoracic common carotid 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. | 10/15/2014 | 12/31/2999 |
| 37218 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 |
| 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 |
| 37501 | Unlisted vascular endoscopy procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 37799 | Unlisted procedure, vascular surgery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 38129 | Unlisted laparoscopy procedure, spleen | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 38589 | Unlisted laparoscopy procedure, lymphatic system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 38999 | Unlisted procedure, hemic or lymphatic system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 39499 | Unlisted procedure, mediastinum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 39599 | Unlisted procedure, diaphragm | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 40799 | Unlisted procedure, lips | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 40899 | Unlisted procedure, vestibule of mouth | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 41599 | Unlisted procedure, tongue, floor of mouth | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 41899 | Unlisted procedure, dentoalveolar structures | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 42299 | Unlisted procedure, palate, uvula | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 42699 | Unlisted procedure, salivary glands or ducts | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |
| 42999 | Unlisted procedure, pharynx, adenoids, or tonsils | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 43289 | Unlisted laparoscopy procedure, esophagus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |
| 43499 | Unlisted procedure, esophagus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 43659 | Unlisted laparoscopy procedure, stomach | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 43999 | Unlisted procedure, stomach | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 44238 | Unlisted laparoscopy procedure, intestine (except rectum) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 | 8/14/2025 |
| 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 |
| 44799 | Unlisted procedure, small intestine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 44899 | Unlisted procedure, Meckel's diverticulum and the mesentery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 44979 | Unlisted laparoscopy procedure, appendix | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 45399 | Unlisted procedure, colon | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2015 | 12/31/2999 |
| 45499 | Unlisted laparoscopy procedure, rectum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006 | 12/31/2999 |
| 45999 | Unlisted procedure, rectum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 46707 | Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 46999 | Unlisted procedure, anus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 47379 | Unlisted laparoscopic procedure, liver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 47399 | Unlisted procedure, liver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 47579 | Unlisted laparoscopy procedure, biliary tract | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 47999 | Unlisted procedure, biliary tract | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 48999 | Unlisted procedure, pancreas | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 49329 | Unlisted laparoscopy procedure, abdomen, peritoneum and omentum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 49412 | Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/3/2016 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 49659 | Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 49999 | Unlisted procedure, abdomen, peritoneum and omentum | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 50250 | Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2008 | 12/31/2999 |
| 50360 | Renal allotransplantation, implantation of graft; without recipient nephrectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2017 | 12/31/2999 |
| 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 |
| 50549 | Unlisted laparoscopy procedure, renal | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 50949 | Unlisted laparoscopy procedure, ureter | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |
| 51999 | Unlisted laparoscopy procedure, bladder | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 53451 | Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 53452 | Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not 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 |
| 53453 | Periurethral transperineal adjustable balloon continence device; removal, each 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). | 10/1/2024 | 12/31/2999 |
| 53454 | Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume | EIU: Procedure/service not 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 |
| 53855 | Insertion of a temporary prostatic urethral stent, including urethral measurement | EIU: Procedure/service not 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 |
| 53860 | Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence | EIU: Procedure/service not 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 53899 | Unlisted procedure, urinary system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 | Effective Date | 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 | Effective Date | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 |
| 54699 | Unlisted laparoscopy procedure, testis | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 55400 | Vasovasostomy, vasovasorrhaphy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 55559 | Unlisted laparoscopy procedure, spermatic cord | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 |
| 55870 | Electroejaculation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 55899 | Unlisted procedure, male genital system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | 8/14/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| 58322 | Artificial insemination; intra-uterine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58323 | Sperm washing for artificial insemination | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58578 | Unlisted laparoscopy procedure, uterus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 58579 | Unlisted hysteroscopy procedure, uterus | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 58580 | Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 58679 | Unlisted laparoscopy procedure, oviduct, ovary | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 58750 | Tubotubal anastomosis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58752 | Tubouterine implantation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58970 | Follicle puncture for oocyte retrieval, any method | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58974 | Embryo transfer, intrauterine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58976 | Gamete, zygote, or embryo intrafallopian transfer, any method | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58999 | Unlisted procedure, female genital system (nonobstetrical) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 59072 | Fetal umbilical cord occlusion, including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 59074 | Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2022 | 12/31/2999 |
| 59076 | Fetal shunt placement, including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2012 | 12/31/2999 |
| 59897 | Unlisted fetal invasive procedure, including ultrasound guidance, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 59897 | Unlisted fetal invasive procedure, including ultrasound guidance, when performed | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 59898 | Unlisted laparoscopy procedure, maternity care and delivery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 59899 | Unlisted procedure, maternity care and delivery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 60659 | Unlisted laparoscopy procedure, endocrine system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 60699 | Unlisted procedure, endocrine system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 61889 | Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s) | 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 |
| 61891 | Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s) | 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 |
| 61892 | Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, 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 |
| 62263 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days | EIU: Procedure/service not 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 |
| 62264 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day | EIU: Procedure/service not 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 |
| 62268 | Percutaneous aspiration, spinal cord cyst or syrinx | 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 | Ending Date |
|---|---|---|---|---|
| 62287 | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 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 | Ending Date |
|---|---|---|---|---|
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (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). | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 64999 | Unlisted procedure, nervous system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 65760 | Keratomileusis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| 65765 | Keratophakia | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 5/31/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 66999 | Unlisted procedure, anterior segment of eye | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 67299 | Unlisted procedure, posterior segment | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 67399 | Unlisted procedure, extraocular muscle | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 |
| 67599 | Unlisted procedure, orbit | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 67999 | Unlisted procedure, eyelids | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 68399 | Unlisted procedure, conjunctiva | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 68899 | Unlisted procedure, lacrimal system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |
| 69399 | Unlisted procedure, external ear | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 69719 | Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2022 | 12/31/2999 |
| 69728 | Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 69729 | Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 69730 | Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 69799 | Unlisted procedure, middle ear | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 69949 | Unlisted procedure, inner ear | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 69979 | Unlisted procedure, temporal bone, middle fossa approach | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 75580 | Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 75894 | Transcatheter therapy, embolization, any method, radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2008 | 12/31/2999 |
| 75958 | Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 75959 | Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 76496 | Unlisted fluoroscopic procedure (eg, diagnostic, interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 76497 | Unlisted computed tomography procedure (eg, diagnostic, interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 76498 | Unlisted magnetic resonance procedure (eg, diagnostic, interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 76499 | Unlisted diagnostic radiographic procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 pre-service review. | 1/1/2005 | 12/31/2999 |
| 76999 | Unlisted ultrasound procedure (eg, diagnostic, interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 77299 | Unlisted procedure, therapeutic radiology clinical treatment planning | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 77399 | Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 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 |
| 77499 | Unlisted procedure, therapeutic radiology treatment management | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 77799 | Unlisted procedure, clinical brachytherapy | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78099 | Unlisted endocrine procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78199 | Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78299 | Unlisted gastrointestinal procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 78399 | Unlisted musculoskeletal procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 78499 | Unlisted cardiovascular procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78599 | Unlisted respiratory procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78699 | Unlisted nervous system procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78799 | Unlisted genitourinary procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 78999 | Unlisted miscellaneous procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 79999 | Radiopharmaceutical therapy, unlisted procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 80299 | Quantitation of therapeutic drug, not elsewhere specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 81099 | Unlisted urinalysis procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 81479 | Unlisted molecular pathology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2013 | 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 |
| 81538 | Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 81599 | Unlisted multianalyte assay with algorithmic analysis | 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 |
| 81599 | Unlisted multianalyte assay with algorithmic analysis | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2013 | 12/31/2999 |
| 82523 | Collagen cross links, any method | EIU: Procedure/service not 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 |
| 82777 | Galectin-3 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 5/31/2025 |
| 83695 | Lipoprotein (a) | EIU: Procedure/service not 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 |
| 83698 | Lipoprotein-associated phospholipase A2 (Lp-PLA2) | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| 83701 | Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2015 | 12/31/2999 |
| 83704 | Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), 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). | 1/15/2015 | 12/31/2999 |
| 83722 | Lipoprotein, direct measurement; small dense LDL cholesterol | EIU: Procedure/service not 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 |
| 83937 | Osteocalcin (bone g1a protein) | EIU: Procedure/service not 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 |
| 83987 | pH; exhaled breath condensate | EIU: Procedure/service not 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 | 5/31/2025 |
| 84112 | Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 84431 | Thromboxane metabolite(s), including thromboxane if performed, urine | EIU: Procedure/service not 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 | 6/30/2025 |
| 84999 | Unlisted chemistry procedure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/3/2016 | 12/31/2999 |
| 84999 | Unlisted chemistry procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 6/20/2014 | 12/31/2999 |
| 85999 | Unlisted hematology and coagulation procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 86001 | Allergen specific IgG quantitative or semiquantitative, each allergen | EIU: Procedure/service not 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 |
| 86328 | Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip); 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 86343 | Leukocyte histamine release test (LHR) | EIU: Procedure/service not 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 |
| 86352 | Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP) | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 86486 | Skin test; unlisted antigen, each | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 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 |
| 86849 | Unlisted immunology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 pre-service 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 |
| 86999 | Unlisted transfusion medicine procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 87797 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 87798 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 87799 | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 87899 | Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 87999 | Unlisted microbiology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 88099 | Unlisted necropsy (autopsy) procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 88199 | Unlisted cytopathology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 88299 | Unlisted cytogenetic study | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2014 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 88399 | Unlisted surgical pathology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 88749 | Unlisted in vivo (eg, transcutaneous) laboratory service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2011 | 12/31/2999 |
| 89240 | Unlisted miscellaneous pathology test | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| 89258 | Cryopreservation; embryo(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 89259 | Cryopreservation; sperm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 89260 | Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| 89268 | Insemination of oocytes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 89272 | Extended culture of oocyte(s)/embryo(s), 4-7 days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 11/1/2015 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 89398 | Unlisted reproductive medicine laboratory procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2010 | 12/31/2999 |
| 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 | 9/30/2025 |
| 90399 | Unlisted immune globulin | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 90584 | Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2022 | 12/31/2999 |
| 90589 | Chikungunya virus vaccine, live attenuated, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 8/22/2025 | 12/31/2999 |
| 90593 | Chikungunya virus vaccine, recombinant, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2025 | 2/13/2025 |
| 90612 | Influenza virus vaccine, trivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 31.7 mcg/0.32 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 90613 | Influenza virus vaccine, quadrivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 40 mcg/0.4 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 90624 | Meningococcal pentavalent vaccine, Men B-4C recombinant proteins and outer membrane vesicle and conjugated Men A, C, W, Y-diphtheria toxoid carrier, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 10/1/2024 | 12/31/2999 |
| 90626 | Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2021 | 12/31/2999 |
| 90627 | Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2021 | 12/31/2999 |
| 90637 | Influenza virus vaccine, quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2024 | 12/31/2999 |
| 90638 | Influenza virus vaccine, quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2024 | 12/31/2999 |
| 90664 | Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 90666 | Influenza virus vaccine (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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 90749 | Unlisted vaccine/toxoid | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 90759 | Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2022 | 12/31/2999 |
| 90867 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90868 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90869 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90875 | Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/2005 | 12/31/2999 |
| 90889 | Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 90899 | Unlisted psychiatric service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 90999 | Unlisted dialysis procedure, inpatient or outpatient | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 91034 | Esophagus, gastroesophageal reflux test; with nasal catheter pH 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 91065 | Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal 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 |
| 91112 | Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91113 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 91117 | Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 91132 | Electrogastrography, diagnostic, transcutaneous; | EIU: Procedure/service not 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 |
| 91133 | Electrogastrography, diagnostic, transcutaneous; with provocative testing | EIU: Procedure/service not 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 |
| 91299 | Unlisted diagnostic gastroenterology procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 92065 | Orthoptic training; performed 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. | 1/1/2019 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 92499 | Unlisted ophthalmological service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 92517 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU 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 |
|---|---|---|---|---|
| 92518 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP) | EIU: Procedure/service not 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 |
| 92519 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP) | EIU: Procedure/service not 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 |
| 92520 | Laryngeal function studies (ie, aerodynamic testing and acoustic testing) | 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 |
| 92548 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including 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 |
| 92549 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT) | EIU: Procedure/service not 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 |
| 92700 | Unlisted otorhinolaryngological service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 | Ending Date |
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| 92979 | Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/5/2018 | 12/31/2999 |
| 93025 | Microvolt T-wave alternans for assessment of ventricular arrhythmias | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2014 | 12/31/2999 |
| 93050 | Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 93150 | Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93151 | Interrogation and programming (minimum one parameter) 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). | 5/15/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 93152 | Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography | EIU: Procedure/service not 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 |
| 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). | 5/15/2024 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(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 |
| 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 |
| 93799 | Unlisted cardiovascular service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 93893 | Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| 93998 | Unlisted noninvasive vascular diagnostic study | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012 | 12/31/2999 |
| 94014 | Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 94015 | Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94016 | Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94669 | Mechanical chest wall oscillation to facilitate lung function, per session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| 94774 | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, review, interpretation, and preparation of a report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 94775 | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitor attachment only (includes hook-up, initiation of recording and disconnection) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 94776 | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; monitoring, download of information, receipt of transmission(s) and analyses by computer only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 94777 | Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; review, interpretation and preparation of report only by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 94799 | Unlisted pulmonary service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 95060 | Ophthalmic mucous membrane tests | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 95065 | Direct nasal mucous membrane test | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 95199 | Unlisted allergy/clinical immunologic service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 95700 | Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 95717 | 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; without video | 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 |
| 95718 | 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) | 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 |
| 95719 | 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 | 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 |
| 95720 | 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) | 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 |
| 95721 | 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 to 60 hours of EEG recording, without video | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 95722 | 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 to 60 hours of EEG recording, with video (VEEG) | 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 |
| 95723 | 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 60 hours, up to 84 hours of EEG recording, without video | 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 |
| 95724 | 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 60 hours, up to 84 hours of EEG recording, with video (VEEG) | 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 |
| 95725 | 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 84 hours of EEG recording, without video | 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 |
| 95726 | 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 84 hours of EEG recording, with video (VEEG) | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 95782 | Polysomnography; younger than 6 years, 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. | 7/15/2022 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 95811 | Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2022 | 12/31/2999 |
| 95905 | Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, 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 | 5/31/2025 |
| 95919 | Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 95954 | Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020 | 12/31/2999 |
| 95957 | Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) | 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 |
|---|---|---|---|---|
| 95961 | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance 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. | 8/1/2015 | 12/31/2999 |
| 95962 | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (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. | 8/1/2015 | 12/31/2999 |
| 95965 | Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| 95966 | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| 95967 | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (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 |
| 95999 | Unlisted neurological or neuromuscular diagnostic procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 96000 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; | 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 |
| 96001 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking | 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 |
| 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 |
| 96379 | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2009 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 |
| 96549 | Unlisted chemotherapy procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 96571 | Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 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 |
| 96573 | Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day | 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 | Ending Date |
|---|---|---|---|---|
| 96574 | Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day | 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 |
| 96912 | Photochemotherapy; psoralens and ultraviolet A (PUVA) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2009 | 12/31/2999 |
| 96913 | Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings) | 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 |
| 96922 | Excimer laser treatment for psoriasis; over 500 sq cm | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, 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 |
| 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 |
| 96999 | Unlisted special dermatological service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 pre-service review. | 5/1/2015 | 12/31/2999 |
| 97014 | Application of a modality to 1 or more areas; electrical stimulation (unattended) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 11/14/2012 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |
| 97039 | Unlisted modality (specify type and time if constant attendance) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 97124 | Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2016 | 12/31/2999 |
| 97139 | Unlisted therapeutic procedure (specify) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 97169 | Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2017 | 12/31/2999 |
| 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 covered by the Plan. Not subject to pre-service review. | 1/1/2017 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 97171 | Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/2017 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 | Effective Date | Ending Date |
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| 97607 | Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions 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. | 1/1/2015 | 12/31/2999 |
| 97608 | Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions 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. | 1/1/2015 | 12/31/2999 |
| 97610 | Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day | EIU: Procedure/service not 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 |
| 97799 | Unlisted physical medicine/rehabilitation service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 97810 | Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2013 | 12/31/2999 |
| 97811 | Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2013 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 97813 | Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2013 | 12/31/2999 |
| 97814 | Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2013 | 12/31/2999 |
| 98962 | Education and training for patient self-management by a nonphysician qualified, health care professional using a standardized curriculum, face-to face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99026 | Hospital mandated on call service; in-hospital, each hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99027 | Hospital mandated on call service; out-of-hospital, each hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99050 | Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99056 | Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 99058 | Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99070 | Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99071 | Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99075 | Medical testimony | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99075 | Medical testimony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99078 | Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99080 | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 99080 | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 99082 | Unusual travel (eg, transportation and escort of patient) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99082 | Unusual travel (eg, transportation and escort of patient) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99199 | Unlisted special service, procedure or report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| 99360 | Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99429 | Unlisted preventive medicine service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 99450 | Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 99455 | Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| 99456 | Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| 99499 | Unlisted evaluation and management service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 99600 | Unlisted home visit service or procedure | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 0052U | Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2018 | 12/31/2999 |
| 0054T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0055T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0062U | Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score | EIU: Procedure/service not 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 0071T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0072T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; 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 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2005 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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) | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0107T | Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0108T | Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0109T | 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 |
| 0110T | Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0175T | Computer-aided detection (CAD) (computer algorithm analysis of digital image 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0202T | Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine | EIU: Procedure/service not 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 |
| 0207T | Evacuation of meibomian glands, automated, using heat and intermittent pressure, 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). | 9/1/2020 | 12/31/2999 |
| 0208T | Pure tone audiometry (threshold), automated; air 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 0209T | Pure tone audiometry (threshold), automated; air and bone | 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 |
| 0210T | Speech audiometry threshold, automated; | 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 |
| 0211T | Speech audiometry threshold, automated; with speech recognition | 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 |
| 0219T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical | EIU: Procedure/service not 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 |
| 0220T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic | EIU: Procedure/service not 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 |
| 0221T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0222T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (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 |
| 0224U | Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(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). | 6/1/2023 | 12/31/2999 |
| 0226U | Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru | EIU: Procedure/service not 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 |
| 0232T | Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation 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). | 12/1/2020 | 12/31/2999 |
| 0253T | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space | 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 |
| 0263T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest | EIU: Procedure/service not 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 | Ending Date |
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| 0264T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest | EIU: Procedure/service not 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 |
| 0265T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy | EIU: Procedure/service not 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 |
| 0266T | Implantation or replacement 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0273T | 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); with programming | 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 |
| 0274T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic | EIU: Procedure/service not 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0275T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0278T | Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes) | EIU: Procedure/service not 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 |
| 0308T | Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2012 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 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 |
| 0329T | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0339T | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Transcatheter mitral valve repair percutaneous approach via the coronary sinus | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016 | 12/31/2999 |
| 0347T | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 | 6/30/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0379T | 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 |
| 0397T | 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 |
| 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 | EIU: Procedure/service not 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 | Ending Date |
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| 0408T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes | 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 |
| 0409T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; 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 |
| 0410T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial 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 |
| 0411T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular 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 |
| 0412T | Removal 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 |
| 0441T | Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 0442T | Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal 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 |
| 0443T | Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (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 |
| 0444U | Oncology (solid organ neoplasia), targeted genomic sequence analysis panel of 361 genes, interrogation for gene fusions, translocations, or other rearrangements, using DNA from formalin-fixed paraffin-embedded (FFPE) tumor tissue, report of clinically significant variant(s) | 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 |
| 0446U | Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 10 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic risk score for current disease activity | 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 |
| 0447U | Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 11 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic prognostic risk score for developing a clinical flare | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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) | 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 |
| 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0490U | Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular-weight melanoma-associated antigen, CD34 and CD45 protein biomarkers, peripheral blood | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 0491U | Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor (ER) protein biomarker-expressing cells, peripheral blood | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2024 | 12/31/2999 |
| 0492U | Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein biomarker-expressing cells, peripheral blood | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2024 | 12/31/2999 |
| 0494T | Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, 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 |
| 0495T | 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; first two hours in sterile field | 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 |
| 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 | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0514U | Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of adalimumab (ADL) levels in venous serum in patients undergoing adalimumab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL) | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 0515T | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery]) | 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 |
| 0515U | Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of infliximab (IFX) levels in venous serum in patients undergoing infliximab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL) | 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 |
| 0516T | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; 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 |
| 0517T | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) 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 |
| 0518T | Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component 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 |
| 0519T | Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter) | 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 |
|---|---|---|---|---|
| 0520T | Removal and replacement 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. | 9/1/2020 | 12/31/2999 |
| 0521T | Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, 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 |
| 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0532T | Removal of intracardiac ischemia monitoring system, including all 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 |
| 0532U | Rare diseases (constitutional disease/hereditary disorders), rapid whole genome and mitochondrial DNA sequencing for single-nucleotide variants, insertions/deletions, copy number variations, peripheral blood, buffy coat, saliva, buccal or tissue sample, results reported as positive or negative | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0533U | Drug metabolism (adverse drug reactions and drug response), genotyping of 16 genes (ie, ABCG2, CYP2B6, CYP2C9, CYP2C19, CYP2C, CYP2D6, CYP3A5, CYP4F2, DPYD, G6PD, GGCX, NUDT15, SLCO1B1, TPMT, UGT1A1, VKORC1), reported as metabolizer status and transporter function | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0537U | Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0538U | Oncology (solid tumor), next-generation targeted sequencing analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis of 600 genes, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and copy number alterations, microsatellite instability, tumor mutation burden, reported as actionable variant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0539U | Oncology (solid tumor), cell-free circulating tumor DNA (ctDNA), 152 genes, next-generation sequencing, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, copy number alterations, and microsatellite instability, using whole-blood samples, mutations with clinical actionability reported as actionable variant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0541U | Cardiovascular disease (HDL reverse cholesterol transport), cholesterol efflux capacity, LC-MS/MS, quantitative measurement of 5 distinct HDL-bound apolipoproteins (apolipoproteins A1, C1, C2, C3, and C4), serum, algorithm reported as prediction of coronary artery disease (pCAD) score | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0543U | Oncology (solid tumor), next-generation sequencing of DNA from formalin-fixed paraffin-embedded (FFPE) tissue of 517 genes, interrogation for single-nucleotide variants, multi-nucleotide variants, insertions and deletions from DNA, fusions in 24 genes and splice variants in 1 gene from RNA, and tumor mutation burden | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 7/1/2019 | 12/31/2999 |
| 0547U | Neurofilament light chain (NfL), chemiluminescent enzyme immunoassay, plasma, quantitative | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| 0550U | Oncology (prostate), enzyme-linked immunosorbent assays (ELISA) for total prostate-specific antigen (PSA) and free PSA, serum, combined with age, previous negative prostate biopsy status, digital rectal examination findings, prostate volume, and image and data reporting of the prostate, algorithm reported as a risk score for the presence of high-grade prostate cancer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| 0552U | Reproductive medicine (preimplantation genetic assessment), analysis for known genetic disorders from trophectoderm biopsy, linkage analysis of disease-causing locus, and when possible, targeted mutation analysis for known familial variant, reported as low-risk or high-risk for familial genetic disorder | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0553U | Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using DNA genomic sequence analysis from embryonic trophectoderm for structural rearrangements, aneuploidy, and a mitochondrial DNA score, results reported as normal/balanced (euploidy/balanced), unbalanced structural rearrangement, monosomy, trisomy, segmental aneuploidy, or mosaic, per embryo tested | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 0554U | Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using DNA genomic sequence analysis from trophectoderm biopsy for aneuploidy, ploidy, a mitochondrial DNA score, and embryo quality control, results reported as normal (euploidy), monosomy, trisomy, segmental aneuploidy, triploid, haploid, or mosaic, with quality control results reported as contamination detected or inconsistent cohort when applicable, per embryo tested | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 0555U | Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using DNA genomic sequence analysis from embryonic trophectoderm for structural rearrangements, aneuploidy, ploidy, a mitochondrial DNA score, and embryo quality control, results reported as normal/balanced (euploidy/balanced), unbalanced structural rearrangement, monosomy, trisomy, segmental aneuploidy, triploid, haploid, or mosaic, with quality control results reported as contamination detected or inconsistent cohort when applicable, per embryo tested | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 0556U | Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific DNA and RNA by real-time PCR, 12 targets, nasopharyngeal or oropharyngeal swab, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0560U | Oncology (minimal residual disease [MRD]), genomic sequence analysis, cell-free DNA, whole blood and tumor tissue, baseline assessment for design and construction of a personalized variant panel to evaluate current MRD and for comparison to subsequent MRD assessments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |
| 0561U | Oncology (minimal residual disease [MRD]), genomic sequence analysis, cell-free DNA, whole blood, subsequent assessment with comparison to initial assessment to evaluate for MRD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |
| 0562U | Oncology (solid tumor), targeted genomic sequence analysis, 33 genes, detection of single-nucleotide variants (SNVs), insertions and deletions, copy-number amplifications, and translocations in human genomic circulating cell-free DNA, plasma, reported as presence of actionable variants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0563U | Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 11 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0564U | Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 10 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 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 |
| 0565U | Oncology (hepatocellular carcinoma), next-generation sequencing methylation pattern assay to detect 6626 epigenetic alterations, cell-free DNA, plasma, algorithm reported as cancer signal detected or not detected | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0566U | Oncology (lung), qPCR-based analysis of 13 differentially methylated regions (CCDC181, HOXA7, LRRC8A, MARCHF11, MIR129-2, NCOR2, PANTR1, PRKCB, SLC9A3, TBR1_2, TRAP1, VWC2, ZNF781), pleural fluid, algorithm reported as a qualitative result | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 0567U | Rare diseases (constitutional/heritable disorders), whole-genome sequence analysis combination of short and long reads, for single-nucleotide variants, insertions/deletions and characterized intronic variants, copy-number variants, duplications/deletions, mobile element insertions, runs of homozygosity, aneuploidy, and inversions, mitochondrial DNA sequence and deletions, short tandem repeat genes, methylation status of selected regions, blood, saliva, amniocentesis, chorionic villus sample or tissue, identification and categorization of genetic variants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 0568U | Neurology (dementia), beta amyloid (AB40, AB42, AB42/40 ratio), tau-protein phosphorylated at residue (eg, pTau217), neurofilament light chain (NfL), and glial fibrillary acidic protein (GFAP), by ultra-high sensitivity molecule array detection, plasma, algorithm reported as positive, intermediate, or negative for Alzheimer pathology | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 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 | Ending Date |
|---|---|---|---|---|
| 0569U | Oncology (solid tumor), next-generation sequencing analysis of tumor methylation markers (>20000 differentially methylated regions) present in cell-free circulating tumor DNA (ctDNA), whole blood, algorithm reported as presence or absence of ctDNA with tumor fraction, if appropriate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |
| 0571U | Oncology (solid tumor), DNA (80 genes) and RNA (10 genes), by next-generation sequencing, plasma, including single-nucleotide variants, insertions/deletions, copy-number alterations, microsatellite instability, and fusions, reported as clinically actionable variants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0572U | Oncology (prostate), high-throughput telomere length quantification by FISH, whole blood, diagnostic algorithm reported as risk of prostate cancer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 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 |
| 0576T | Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter | 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 | Ending Date |
|---|---|---|---|---|
| 0577T | Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (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. | 2/15/2025 | 12/31/2999 |
| 0578T | Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) 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. | 2/15/2025 | 12/31/2999 |
| 0579T | Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results | 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 |
| 0580T | Removal of substernal implantable defibrillator pulse generator only | 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 |
| 0587T | Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve | 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 |
| 0588T | Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0589T | Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (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, posterior tibial nerve, 1-3 parameters | 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 |
| 0590T | Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (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, posterior tibial nerve, 4 or more parameters | 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 |
| 0596T | Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement | 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 |
| 0597T | Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0599T | 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 |
| 0600T | 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 | EIU: Procedure/service not 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 |
| 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 | Ending Date |
|---|---|---|---|---|
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0629T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT 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 |
| 0630T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT 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 |
| 0631T | Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per 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). | 1/1/2021 | 12/31/2999 |
| 0632T | Percutaneous transcatheter ultrasound 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0639T | Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, 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 |
| 0640T | Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site | EIU: Procedure/service not 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 |
| 0643T | Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach | 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 |
| 0645T | Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed | 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 |
| 0646T | Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed | 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 |
| 0650T | Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0651T | Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0656T | Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 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 |
| 0659T | 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 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0667T | Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0668T | Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary | EIU: Procedure/service not 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 |
| 0669T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0670T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0672T | Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence | EIU: Procedure/service not 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 |
| 0692T | Therapeutic ultrafiltration | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | 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 |
| 0722T | Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0726T | 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 |
| 0727T | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | EIU: Procedure/service not 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 |
| 0744T | Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), 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). | 9/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0764T | Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0765T | Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0766T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0767T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0770T | Virtual reality technology to assist therapy (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0771T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0772T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0773T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; 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 |
| 0774T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0776T | Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0777T | Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0778T | Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0779T | Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0780T | Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 0781T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0782T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0783T | Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0784T | Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| 0785T | Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| 0786T | Insertion or replacement of percutaneous electrode array, sacral, with 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 | Revision or removal of neurostimulator electrode array, sacral, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0792T | Application of silver diamine fluoride 38%, by a physician or other qualified health care professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0793T | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0798T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), 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 |
| 0799T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component | 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 |
| 0800T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), 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 | Ending Date |
|---|---|---|---|---|
| 0801T | 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; dual-chamber 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 |
| 0802T | 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 atrial pacemaker component | 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0811T | Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 0812T | 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| 0813T | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0814T | Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| 0816T | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0817T | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0822T | Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; clinical staff under the direction of a 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 0823T | Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) 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. | 5/15/2024 | 12/31/2999 |
| 0824T | Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 0825T | Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) 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. | 5/15/2024 | 12/31/2999 |
| 0826T | 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, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0859T | Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (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. | 5/15/2025 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0866T | 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 | 6/14/2025 |
| 0868T | High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, 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). | 6/15/2025 | 12/31/2999 |
| 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 | 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 |

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| 0909T | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0916T | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; 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 |
| 0917T | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; single transvenous lead (pacing or defibrillation) 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 |
| 0918T | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; dual transvenous leads (pacing and defibrillation) 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 |
| 0919T | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); 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 |
| 0920T | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous pacing lead 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0921T | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0928T | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system with interim 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. | 1/1/2025 | 12/31/2999 |
| 0929T | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results | 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 |
| 0930T | Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator 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 |
| 0931T | Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), separate from initial implantation or replacement with testing of cardiac contractility modulation defibrillator 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0932T | Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2025 | 12/31/2999 |
| 0933T | Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring, including sensor calibration and deployment, right heart catheterization, transseptal puncture, imaging guidance, and radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2025 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0939T | 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 |
| 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 |
| 0942T | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 0948T | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review 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. | 7/1/2025 | 12/31/2999 |
| 0949T | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0950T | Ablation of benign 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. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0951T | Totally implantable active middle ear hearing implant; initial placement, including mastoidectomy, placement of and attachment to sound processor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0952T | Totally implantable active middle ear hearing implant; revision or replacement, with mastoidectomy and replacement of sound processor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0953T | Totally implantable active middle ear hearing implant; revision or replacement, without mastoidectomy and replacement of sound processor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0954T | Totally implantable active middle ear hearing implant; replacement of sound processor only, with attachment to existing transducers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0955T | Totally implantable active middle ear hearing implant; removal, including removal of sound processor and all implant components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0961T | Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (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. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0961T | Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0962T | Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg, reduced ejection fraction, cardiac murmurs, atrial fibrillation), with 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. | 7/1/2025 | 12/31/2999 |
| 0963T | Anoscopy with directed submucosal injection of bulking agent into anal canal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0964T | Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0965T | Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0966T | Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0967T | Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0967T | Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0970T | Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0971T | Ablation, malignant breast tumor(s), percutaneous, laser, including imaging guidance when performed, unilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0972T | Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0977T | Upper gastrointestinal blood detection, sensor capsule, with interpretation and report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0978T | Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0979T | Submucosal cryolysis therapy; soft palate only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0980T | Submucosal cryolysis therapy; base of tongue and lingual tonsil only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0981T | Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0981T | Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0982T | Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0982T | Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0983T | Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area 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. | 7/1/2025 | 12/31/2999 |
| 0983T | Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0984T | Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological 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. | 7/1/2025 | 12/31/2999 |
| 0984T | Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0985T | Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 0985T | Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0986T | Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological 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. | 7/1/2025 | 12/31/2999 |
| 0986T | Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |
| 0987T | Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| 0987T | Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 9701A | NON-PRESCRIPTION DRUGS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| A0100 | Non-emergency transportation; taxi | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0110 | Non-emergency transportation and bus, intra or inter state carrier | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0120 | Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0130 | Non-emergency transportation: wheel-chair van | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0140 | Non-emergency transportation and air travel (private or commercial) intra or inter state | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0160 | Non-emergency transportation: per mile - case worker or social worker | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A0170 | Transportation ancillary: parking fees, tolls, other | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0180 | Non-emergency transportation: ancillary: lodging-recipient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0190 | Non-emergency transportation: ancillary: meals-recipient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0200 | Non-emergency transportation: ancillary: lodging escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0210 | Non-emergency transportation: ancillary: meals-escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/3/2006 | 12/31/2999 |
| 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 pre-service 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 pre-service review. | 4/2/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| A0998 | AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2016 | 12/31/2999 |
| A0999 | Unlisted ambulance service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| A2001 | Innovamatrix ac, 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). | 4/15/2022 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A2002 | Mirragen advanced wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2004 | Xcellistem, 1 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). | 4/15/2022 | 12/31/2999 |
| A2005 | Microlyte 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). | 4/15/2022 | 12/31/2999 |
| A2006 | Novosorb synpath dermal 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). | 4/15/2022 | 12/31/2999 |
| A2007 | Restrata, 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). | 4/15/2022 | 12/31/2999 |
| A2008 | Theragenesis, 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). | 4/15/2022 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A2009 | Symphony, 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). | 4/15/2022 | 12/31/2999 |
| A2010 | Apis, 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). | 4/15/2022 | 12/31/2999 |
| A2011 | Supra sdrm, 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). | 4/1/2022 | 12/31/2999 |
| A2012 | Suprathel, 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). | 4/1/2022 | 12/31/2999 |
| A2013 | Innovamatrix fs, 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). | 4/1/2022 | 12/31/2999 |
| A2014 | Omeza collagen matrix, per 100 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). | 4/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A2015 | Phoenix wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2016 | Permeaderm b, 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). | 4/1/2023 | 12/31/2999 |
| A2017 | Permeaderm glove, 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). | 4/1/2023 | 12/31/2999 |
| A2018 | Permeaderm c, 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). | 4/1/2023 | 12/31/2999 |
| A2019 | Kerecis omega3 marigen shield, 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). | 9/1/2023 | 12/31/2999 |
| A2020 | Ac5 advanced wound system (ac5) | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| A2021 | Neomatrix, 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). | 9/1/2023 | 12/31/2999 |
| A2022 | Innovaburn or innovamatrix xl, 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). | 10/1/2023 | 12/31/2999 |
| A2023 | Innovamatrix pd, 1 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). | 10/1/2023 | 12/31/2999 |
| A2024 | Resolve matrix or xenopatch, 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). | 10/1/2023 | 12/31/2999 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A2030 | Miro3d fibers, per milligram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2030 | Miro3d fibers, per milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025 | 12/31/2999 |
| A2031 | Mirodry wound matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2031 | Mirodry wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025 | 12/31/2999 |
| A2032 | Myriad matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2032 | Myriad 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A2033 | Myriad morcells, 4 milligrams | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2033 | Myriad morcells, 4 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). | 9/15/2025 | 12/31/2999 |
| A2034 | Foundation drs solo, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2034 | Foundation drs solo, 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). | 9/15/2025 | 12/31/2999 |
| A2035 | Corplex p or theracor p or allacor p, per milligram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| A2035 | Corplex p or theracor p or allacor p, per milligram | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| A4335 | Incontinence supply; miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |
| A4421 | Ostomy supply; miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A4457 | Enema tube, with or without adapter, any type, replacement only, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| A4458 | Enema bag with tubing, reusable | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| A4593 | Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2025 | 12/31/2999 |
| A4594 | Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2025 | 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 pre-service review. | 1/25/2013 | 12/31/2999 |
| 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 pre-service review. | 4/15/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| A4641 | RADIOPHARMACEUTICAL, DIAGNOSTIC, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| A4649 | Surgical supply; miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| A4660 | Sphygmomanometer/blood pressure apparatus with cuff and stethoscope | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4663 | Blood pressure cuff only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4913 | Miscellaneous dialysis supplies, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A4930 | Gloves, sterile, per pair | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4931 | Oral thermometer, reusable, any type, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| A5507 | For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 |
| A6261 | WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| A6262 | WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A6512 | Compression burn garment, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| A6519 | Gradient compression garment, not otherwise specified, for nighttime use, each | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2025 | 12/31/2999 |
| A6549 | Gradient compression garment, not otherwise specified, for daytime use, each | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 pre-service 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 pre-service 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A9150 | Non-prescription drugs | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A9152 | SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005 | 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 pre-service review. | 1/1/2005 | 12/31/2999 |
| A9153 | MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005 | 12/31/2999 |
| A9153 | MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| A9180 | PEDICULOSIS (LICE INFESTATION) TREATMENT, TOPICAL, FOR ADMINISTRATION BY PATIENT/CARETAKER | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| A9268 | Programmer for transient, orally ingested capsule | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2025 | 5/31/2025 |
| A9269 | Programable, transient, orally ingested capsule, for use with external programmer, per month | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2025 | 5/31/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A9270 | Non-covered item or service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A9272 | Wound suction, disposable, includes dressing, all accessories and components, any type, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2013 | 12/31/2999 |
| A9273 | Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A9279 | MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2007 | 12/31/2999 |
| A9280 | Alert or alarm device, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| A9281 | REACHING/GRABBING DEVICE, ANY TYPE, ANY LENGTH, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 |
| A9579 | INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, NOT OTHERWISE SPECIFIED (NOS), per ml | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| A9597 | Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017 | 12/31/2999 |
| A9598 | Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| A9611 | Flurpiridaz f 18, diagnostic, 1 millicurie | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| A9698 | NON-RADIOACTIVE CONTRAST IMAGING MATERIAL, NOT OTHERWISE CLASSIFIED, PER STUDY | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006 | 12/31/2999 |
| A9699 | RADIOPHARMACEUTICAL, THERAPEUTIC, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| A9900 | Miscellaneous dme supply, accessory, and/or service component of another hcpcs code | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| A9999 | Miscellaneous dme supply or accessory, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 pre-service review. | 1/1/2005 | 12/31/2999 |
| B4103 | ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4104 | ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4105 | In-line cartridge containing digestive enzyme(s) for enteral feeding, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| B4149 | ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| B4150 | Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| B4153 | Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| B4154 | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| B4155 | Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e. G. Glucose polymers), proteins/amino acids (e. G. Glutamine, arginine), fat (e. G. Medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| B4157 | ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| B4158 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| B4159 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| B4160 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| B4161 | ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| B4162 | ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| B4164 | Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (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 |
| B4168 | Parenteral nutrition solution; amino acid, 3. 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 |
| B4172 | Parenteral nutrition solution; amino acid, 5. 5% through 7%, (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 |
| 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 | Parenteral nutrition solution; carbohydrates (dextrose), greater 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| B5100 | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-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 |
| B5200 | 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 | 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 |
| B9004 | Parenteral nutrition infusion pump, portable | 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 | Ending Date |
|---|---|---|---|---|
| B9006 | Parenteral nutrition infusion pump, stationary | 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 |
| B9998 | Noc for enteral supplies | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015 | 12/31/2999 |
| B9999 | Noc for parenteral supplies | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| C1052 | Hemostatic agent, gastrointestinal, topical | EIU: Procedure/service not 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 |
| C1062 | Intravertebral body fracture augmentation with implant (e.g., metal, polymer) | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| C1735 | Catheter(s), intravascular for renal denervation, radiofrequency, including all single use 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). | 6/15/2025 | 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 | 6/14/2025 |
| C1736 | Catheter(s), intravascular for renal denervation, ultrasound, including all single use 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). | 6/15/2025 | 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller | EIU: Procedure/service not 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 |
| C1832 | Autograft suspension, including cell processing and application, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| C1889 | Implantable/insertable device, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017 | 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 |
| 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 |
| C2698 | BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| C2699 | BRACHYTHERAPY SOURCE, NON-STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| C8002 | Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025 | 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 |
| 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2025 | 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 against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2025 | 6/30/2025 |
| C9174 | Injection, datopotamab deruxtecan-dlnk, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| C9301 | Obecabtagene autoleucel, up to 400 million 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. | 4/1/2025 | 6/30/2025 |
| C9302 | Injection, zanidatamab-hrii, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 6/30/2025 |
| C9303 | Injection, zolbetuximab-clzb, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 6/30/2025 |
| C9354 | Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| C9356 | Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9358 | Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9360 | Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9363 | Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| C9364 | Porcine implant, Permacol, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9399 | unclassified drugs or biologicals | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| C9734 | Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2014 | 12/31/2999 |
| C9739 | Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| C9740 | Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| C9757 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| C9764 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |
| C9765 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | EIU: Procedure/service not 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 |
| 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 |
| C9774 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| C9775 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, 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 |
| C9777 | Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy | EIU: Procedure/service not 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 |
| C9780 | Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance | 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 |
| C9782 | Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., 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 | 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 |
| C9784 | Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring 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). | 12/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| C9785 | Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring 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). | 12/1/2023 | 12/31/2999 |
| C9793 | 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging 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 |
| C9796 | Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 8/14/2025 |
| C9807 | Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode 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 the caa, 2023) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2025 | 6/14/2025 |
| C9807 | Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode 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 the caa, 2023) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| C9808 | Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe 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 the caa, 2023) | 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 |
| 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 the caa, 2023) | 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 |
| C9898 | Radiolabeled product provided during a hospital inpatient stay | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012 | 12/31/2999 |
| C9899 | IMPLANTED PROSTHETIC DEVICE, PAYABLE ONLY FOR INPATIENTS WHO DO NOT HAVE INPATIENT COVERAGE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012 | 12/31/2999 |
| D0372 | intraoral tomosynthesis ? comprehensive series of radiographic images | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0373 | intraoral tomosynthesis ? bitewing radiographic image | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0374 | intraoral tomosynthesis ? periapical radiographic image | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| D0387 | intraoral tomosynthesis ? comprehensive series of radiographic images - image capture only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0388 | intraoral tomosynthesis ? bitewing radiographic image - image capture only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0389 | intraoral tomosynthesis ? periapical radiographic image - image capture only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0396 | 3D printing of a 3D dental surface scan | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| D0801 | 3D intraoral surface scan - direct | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| D0803 | 3D facial surface scan ? direct | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0804 | 3D facial surface scan ? indirect | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D0999 | unspecified diagnostic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D1301 | Immunization counseling | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| D1705 | AstraZeneca Covid-19 vaccine administration ? first dose | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2021 | 12/31/2999 |
| D1706 | AstraZeneca Covid-19 vaccine administration ? second dose | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/15/2021 | 12/31/2999 |
| D1999 | unspecified preventive procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D2989 | excavation of a tooth resulting in the determination of non-restorability | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| D2991 | application of hydroxyapatite regeneration medicament - per tooth | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| D2999 | unspecified restorative procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D3999 | unspecified endodontic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D4999 | unspecified periodontal procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| D5899 | unspecified removable prosthodontic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D5999 | unspecified maxillofacial prosthesis, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D6105 | removal of implant body not requiring bone removal nor flap elevation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D6197 | replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| D6199 | unspecified implant procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D6999 | unspecified fixed prosthodontic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D7939 | indexing for osteotomy using dynamic robotic assisted or dynamic navigation | 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 |
|---|---|---|---|---|
| D7999 | unspecified oral surgery procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D8999 | unspecified orthodontic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| D9938 | fabrication of a custom removable clear plastic temporary aesthetic appliance | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| D9999 | unspecified adjunctive procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E0201 | 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. | 4/1/2025 | 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 |
| E0218 | Fluid circulating cold pad with pump, 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| E0221 | Infrared heating pad 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 |
| E0225 | Hydrocollator unit, includes pads | 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 |
| E0231 | Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover | EIU: Procedure/service not 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 |
| E0232 | Warming card for use with the non contact wound warming device and non contact wound warming wound cover | EIU: Procedure/service not 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 |
| E0236 | Pump for water circulating pad | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E0240 | Bath/shower chair, with or without wheels, any size | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service review. | 5/15/2021 | 12/31/2999 |
| E0243 | Toilet rail, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2021 | 12/31/2999 |
| E0244 | Raised toilet seat | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2021 | 12/31/2999 |
| E0245 | Tub stool or bench | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2021 | 12/31/2999 |
| E0246 | Transfer tub rail attachment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service review. | 5/15/2021 | 12/31/2999 |
| 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 |

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

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

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E0446 | TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| E0468 | Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Implantable cardiac event recorder with memory, activator and programmer | 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 | External defibrillator with integrated electrocardiogram analysis | 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E0625 | Patient lift, bathroom or toilet, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 12/21/2004 | 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 |
| 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 |

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| E0676 | INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 3/20/2019 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 |
| 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 pre-service review. | 1/25/2013 | 12/31/2999 |
| E0731 | Form fitting conductive garment for delivery of tens or nmes (with conductive fibers separated from the patient's skin by layers of fabric) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E0732 | Cranial electrotherapy stimulation (ces) system, any type | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0733 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0735 | Non-invasive vagus nerve stimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| E0736 | Transcutaneous tibial nerve stimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E0738 | Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2025 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E0769 | ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E0770 | FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2009 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E0840 | Traction frame, attached to headboard, cervical traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0849 | TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0850 | Traction stand, free standing, cervical traction | EIU: Procedure/service not reimbursed by the Plan. 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 |
| E0855 | Cervical traction equipment not requiring additional stand or frame | EIU: Procedure/service not 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 |
| E0856 | Cervical traction device, with inflatable air bladder(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). | 12/15/2014 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E0860 | Traction equipment, overdoor, cervical | EIU: Procedure/service not 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 (CPCP). | 9/1/2020 | 12/31/2999 |
| E0944 | Pelvic belt/harness/boot | EIU: Procedure/service not 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 |
| E0946 | Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster) | 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 |

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

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E1022 | Wheelchair transportation securement system, any type includes all components and accessories | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| E1023 | Wheelchair transit securement system, includes all components and accessories | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| E1032 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| E1033 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| E1034 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 | Effective Date | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E1229 | WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| E1239 | POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| E1399 | Durable medical equipment, miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/15/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| E1639 | Scale, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| E1699 | Dialysis equipment, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 | Effective Date | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| E2329 | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| E2331 | Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| E2374 | POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY | 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 |
| E2375 | POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY | 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 |
| E2376 | POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY | 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 |
| E2377 | POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE | 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 |
| E2397 | POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, 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 |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable | 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 | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 |
| E2599 | Accessory for speech generating device, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| E2620 | POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, 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 |
| 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | 5/31/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| G0235 | Pet imaging, any site, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2015 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | EIU: Procedure/service not 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 |
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service review. | 5/11/2022 | 12/31/2999 |
| G0312 | Immunization counseling by a physician or other qualify ed health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 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 pre-service review. | 5/11/2022 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 pre-service 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| G0516 | Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant) | 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 | Removal with reinsertion, non-biodegradable drug delivery 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 |
| G0552 | Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025 | 12/31/2999 |
| G0553 | First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar 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). | 6/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| G0554 | Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar 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). | 6/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| G0556 | Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at 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- | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| G0557 | Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until 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. ++ medication reconciliation, management and oversight of self- | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G0558 | Advanced primary care management services for a patient that is a qualified medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until 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. ++ medication reconciliation, management | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| G0561 | Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583t) | 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 |
| G2011 | Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2019 | 12/31/2999 |
| G2082 | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2021 | 12/31/2999 |
| G2083 | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using g3002, 30 minutes must be met or exceeded.) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G8397 | DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8399 | Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8400 | Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8404 | LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8405 | LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8410 | FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8415 | FOOTWEAR EVALUATION WAS NOT PERFORMED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8416 | CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8417 | Bmi is documented above normal parameters and a follow-up plan is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8418 | Bmi is documented below normal parameters and a follow-up plan is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G8419 | Bmi documented outside normal parameters, no follow-up plan documented, no reason given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8420 | Bmi is documented within normal parameters and no follow-up plan is required | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8421 | Bmi not documented and no reason is given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service review. | 1/1/2008 | 12/31/2999 |
| G8430 | Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/2008 | 12/31/2999 |
| G8432 | Depression screening not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8433 | Screening for depression not completed, documented patient or medical reason | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8450 | Beta-blocker therapy prescribed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G8451 | Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8452 | Beta-blocker therapy not prescribed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8465 | High or very high risk of recurrence of prostate cancer | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8473 | ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8474 | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8475 | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8476 | Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8477 | Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G8478 | Blood pressure measurement not performed or documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G9012 | Other specified case management service not elsewhere classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| G9050 | Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 pre-service 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 pre-service 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 medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9059 | Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9069 | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9072 | 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 pr negative; 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G9073 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9074 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9075 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9077 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9078 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G9079 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9080 | Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9083 | Oncology; disease status; prostate 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9084 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9085 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9086 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G9087 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9099 | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9100 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9101 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| G9102 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9103 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9104 | Oncology; disease status; gastric cancer, limited to 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service 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 medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| G9123 | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9124 | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9125 | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| G9126 | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9128 | Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage i (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9129 | Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9130 | Oncology; disease status; limited to multiple myeloma, systemic disease; 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 pre-service review. | 1/1/2006 | 12/31/2999 |
| 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 pre-service review. | 10/1/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| H0038 | Self-help/peer services, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0039 | Assertive community treatment, face-to-face, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0040 | Assertive community treatment program, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0041 | Foster care, child, non-therapeutic, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| H0042 | Foster care, child, non-therapeutic, per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0043 | Supported housing, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0044 | Supported housing, per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0045 | Respite care services, not in the home, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H0046 | Mental health services, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| H0047 | Alcohol and/or other drug abuse services, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| H0051 | Traditional healing service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| H1010 | Non-medical family planning education, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H1011 | Family assessment by licensed behavioral health professional for state defined purposes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| H2024 | Supported employment, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2025 | Ongoing support to maintain employment, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2026 | Ongoing support to maintain employment, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2027 | Psychoeducational service, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2028 | Sexual offender treatment service, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2029 | Sexual offender treatment service, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2030 | Mental health clubhouse services, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2031 | Mental health clubhouse services, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2032 | Activity therapy, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2033 | Multisystemic therapy for juveniles, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| H2034 | Alcohol and/or drug abuse halfway house services, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| H2037 | Developmental delay prevention activities, dependent child of client, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 | 5/31/2025 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J0220 | INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| J0222 | Injection, Patisiran, 0.1 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J0256 | INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| J1072 | Injection, testosterone cypionate (azmiro), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| J1299 | Injection, eculizumab, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| J1301 | Injection, edaravone, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J1302 | Injection, sutimlimab-jome, 10 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 |
| J1303 | Injection, ravulizumab-cwvz, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2020 | 12/31/2999 |
| J1304 | Injection, tofersen, 1 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 |
| J1305 | Injection, evinacumab-dgnb, 5mg | 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 |
| J1306 | Injection, inclisiran, 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 |
| J1307 | Injection, crovalimab-akkz, 10 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J1323 | Injection, elranatamab-bcmm, 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 |
| J1325 | Injection, epoprostenol, 0. 5 mg | 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 |
| J1326 | Injection, zolbetuximab-clzb, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| J1411 | Injection, etranacogene dezaparvovec-drlb, per therapeutic dose | 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 |
| J1412 | Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes | 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 |
| J1413 | Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose | 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 |
|---|---|---|---|---|
| J1414 | 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 review. | 1/1/2025 | 9/30/2025 |
| J1426 | Injection, casimersen, 10 mg | 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 |
| J1427 | Injection, viltolarsen, 10 mg | 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 |
| J1428 | Injection, eteplirsen, 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 |
| J1429 | Injection, golodirsen, 10 mg | 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 |
| J1440 | Fecal microbiota, live - jslm, 1 ml | 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 | Ending Date |
|---|---|---|---|---|
| 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 |
| J1566 | Injection, immune globulin, intravenous, lyophilized (e. G. Powder), not otherwise specified, 500 mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |
| J1599 | INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 7/15/2023 | 12/31/2999 |
| J1729 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| J1729 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| 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 | 3/31/2025 |
| J2351 | Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| J2354 | 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. | 3/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J2356 | Injection, tezepelumab-ekko, 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 |
| J2440 | 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. | 2/15/2007 | 12/31/2999 |
| J2502 | 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. | 10/1/2024 | 9/30/2025 |
| J2508 | 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. | 1/1/2024 | 12/31/2999 |
| J2777 | Injection, faricimab-svoa, 0.1 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| J3055 | 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. | 4/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J3111 | Injection, romosozumab-aqqg, 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 |
| J3121 | Injection, testosterone enanthate, 1mg | 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 |
| J3145 | Injection, testosterone undecanoate, 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 |
| J3241 | Injection, teprotumumab-trbw, 10 mg | 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 |
| J3247 | Injection, secukinumab, intravenous, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2024 | 12/31/2999 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J3355 | INJECTION, UROFOLLITROPIN, 75 IU | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| J3391 | Injection, atidarsagene autotemcel, per treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| J3490 | Unclassified drugs | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| J3570 | Laetrile, amygdalin, vitamin b17 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 6/1/2015 | 12/31/2999 |
| J3590 | Unclassified biologics | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J3591 | Unclassified drug or biological used for esrd on dialysis | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2019 | 12/31/2999 |
| J7183 | INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| J7192 | FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U., NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| J7195 | Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| J7199 | Hemophilia clotting factor, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7308 | Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form (354 mg) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| J7309 | METHYL AMINOLEVULINATE (MAL) FOR TOPICAL ADMINISTRATION, 16.8%, 1 GRAM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| J7311 | Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2011 | 12/31/2999 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| J7356 | Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| J7599 | Immunosuppressive drug, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| J7609 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 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 |
| J7610 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 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 | Ending Date |
|---|---|---|---|---|
| J7615 | LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 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 |
| J7622 | BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7624 | BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7627 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 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 |
| J7628 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7629 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7632 | CROMOLYN SODIUM, 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 |
| J7634 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7635 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7636 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7637 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7638 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7640 | FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7641 | FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7642 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7643 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7645 | IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7647 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7650 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7657 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7660 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7667 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7670 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7676 | PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7680 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7681 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7683 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7684 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7685 | TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7699 | Noc drugs, inhalation solution administered through dme | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J7799 | Noc drugs, other than inhalation drugs, administered through dme | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| J7999 | Compounded drug, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2016 | 12/31/2999 |
| J8498 | ANTIEMETIC DRUG, RECTAL/SUPPOSITORY, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006 | 12/31/2999 |
| J8499 | Prescription drug, oral, non chemotherapeutic, nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| J8597 | ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006 | 12/31/2999 |
| J8999 | Prescription drug, oral, chemotherapeutic, nos | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J9020 | Injection, asparaginase, not otherwise specified, 10,000 units | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| J9024 | Injection, atezolizumab, 5 mg and hyaluronidase-tqjs | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| J9029 | Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| J9037 | Injection, belantamab mafodontin-blmf, 0.5 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 3/31/2025 |
| J9038 | Injection, axatilimab-csfr, 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| J9054 | Injection, bortezomib (boruzu), 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J9056 | Injection, bendamustine hydrochloride (vivimusta), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| J9057 | Injection, copanlisib, 1 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| 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 |
| J9161 | Injection, denileukin diftitox-cxdl, 1 mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| J9174 | Injection, docetaxel (beizray), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| J9275 | Injection, cosibelimab-ipdl, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| J9276 | Injection, zanidatamab-hrii, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| J9285 | Injection, olaratumab, 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |
| J9289 | Injection, nivolumab, 2 mg and hyaluronidase-nvhy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| J9313 | Injection, moxetumomab pasudotox-tdfk, 0.01 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| J9333 | Injection, rozanolixizumab-noli, 1 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 |
| J9334 | 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. | 1/1/2024 | 12/31/2999 |
| J9341 | Injection, thiotepa (tepylute), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J9342 | Injection, thiotepa, not otherwise specified, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| J9347 | Injection, tremelimumab-actl, 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 |
| J9350 | Injection, mosunetuzumab-axgb, 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 |
| J9376 | Injection, pozelimab-bbfg, 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 |
| J9380 | Injection, teclistamab-cqyv, 0.5 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| J9382 | Injection, zenocutuzumab-zbco, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 |
| J9999 | Not otherwise classified, antineoplastic drugs | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| K0009 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| K0053 | 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 |
| K0056 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| K0108 | Wheelchair component or accessory, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 2/9/2017 | 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 |
| K0743 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| K0800 | 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 |
| K0802 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0806 | 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 |
| 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 |
| K0812 | POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 2/9/2017 | 12/31/2999 |
| K0813 | POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| K0815 | 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 |
| 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 |
| K0822 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0823 | 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 | POWER WHEELCHAIR, GROUP 2 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 |
| K0826 | POWER WHEELCHAIR, GROUP 2 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0829 | 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 |
| K0830 | 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 |
| 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 |
| K0836 | POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/27/2009 | 12/31/2999 |
| K0837 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0838 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| K0852 | 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 |
| K0853 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0854 | 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 |
| K0855 | 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 |
| 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 |
| K0858 | 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 |
| K0859 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0860 | 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 |
| 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 |
| K0864 | 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 |
| K0868 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0869 | 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 |
| K0870 | 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 |
| 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 |
| K0878 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0880 | POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended 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 |
| 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 |
| K0890 | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/27/2009 | 12/31/2999 |
| K0891 | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/27/2009 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K0898 | POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/1/2006 | 12/31/2999 |
| K0899 | Power mobile device; no dme pdac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K1004 | Low frequency ultrasonic diathermy treatment device for home use | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| K1007 | Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| K1027 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| K1034 | Provision of COVID-19 test, nonprescription self-administered and self-collected use, FDA approved, authorized or cleared, one test count | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/12/2023 | 12/31/2999 |
| K1035 | Molecular diagnostic test reader, nonprescription self-administered and self-collected use, fda approved, authorized or cleared | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2023 | 12/31/2999 |
| K1036 | Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| L0120 | Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 11/1/2015 | 12/31/2999 |
| L0999 | Addition to spinal orthosis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 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 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L1499 | Spinal orthosis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2014 | 12/31/2999 |
| L2999 | Lower extremity orthoses, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| L3001 | Foot, insert, removable, molded to patient model, spenco, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3002 | Foot, insert, removable, molded to patient model, plastazote or equal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3003 | Foot, insert, removable, molded to patient model, silicone gel, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| 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-service review. | 5/15/2007 | 12/31/2999 |
| L3020 | Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3030 | Foot, insert, removable, formed to patient foot, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3031 | Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/1/2009 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3040 | Foot, arch support, removable, premolded, longitudinal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3050 | Foot, arch support, removable, premolded, metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3060 | Foot, arch support, removable, premolded, longitudinal/ metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3070 | Foot, arch support, non-removable attached to shoe, longitudinal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3080 | Foot, arch support, non-removable attached to shoe, metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3090 | Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 5/15/2007 | 12/31/2999 |
| L3100 | Hallus-valgus night dynamic splint, prefabricated, off-the-shelf | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3140 | Foot, abduction rotation bar, including shoes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3150 | Foot, abduction rotatation bar, without shoes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3160 | Foot, adjustable shoe-styled positioning device | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3170 | Foot, plastic, silicone or equal, heel stabilizer, prafabricated, off-the-shelf, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3201 | Orthopedic shoe, oxford with supinator or pronator, infant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3202 | Orthopedic shoe, oxford with supinator or pronator, child | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3203 | Orthopedic shoe, oxford with supinator or pronator, junior | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3204 | Orthopedic shoe, hightop with supinator or pronator, infant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3206 | Orthopedic shoe, hightop with supinator or pronator, child | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3207 | Orthopedic shoe, hightop with supinator or pronator, junior | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3212 | Benesch boot, pair, infant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3213 | Benesch boot, pair, child | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3214 | Benesch boot, pair, junior | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3215 | ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3216 | ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3217 | ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3219 | ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3221 | ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3222 | ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3224 | Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3225 | Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3230 | ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3250 | Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3251 | Foot, shoe molded to patient model, silicone shoe, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3252 | Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3253 | Foot, molded shoe plastazote (or similar) custom fitted, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3254 | Non-standard size or width | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3255 | Non-standard size or length | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3257 | Orthopedic footwear, additional charge for split size | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3265 | Plastazote sandal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3300 | Lift, elevation, heel, tapered to metatarsals, per inch | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3310 | Lift, elevation, heel and sole, neoprene, per inch | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3320 | Lift, elevation, heel and sole, cork, per inch | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3330 | Lift, elevation, metal extension (skate) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3332 | Lift, elevation, inside shoe, tapered, up to one-half inch | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3334 | Lift, elevation, heel, per inch | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3340 | Heel wedge, sach | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3350 | Heel wedge | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3360 | Sole wedge, outside sole | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3370 | Sole wedge, between sole | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3380 | Clubfoot wedge | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3390 | Outflare wedge | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3400 | Metatarsal bar wedge, rocker | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3410 | Metatarsal bar wedge, between sole | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3420 | Full sole and heel wedge, between sole | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3430 | Heel, counter, plastic reinforced | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3440 | Heel, counter, leather reinforced | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3450 | Heel, sach cushion type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3455 | Heel, new leather, standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3460 | Heel, new rubber, standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3465 | Heel, thomas with wedge | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3470 | Heel, thomas extended to ball | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3480 | Heel, pad and depression for spur | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3485 | Heel, pad, removable for spur | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3500 | Orthopedic shoe addition, insole, leather | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3510 | Orthopedic shoe addition, insole, rubber | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3520 | Orthopedic shoe addition, insole, felt covered with leather | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3530 | Orthopedic shoe addition, sole, half | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3540 | Orthopedic shoe addition, sole, full | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3550 | Orthopedic shoe addition, toe tap standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3560 | Orthopedic shoe addition, toe tap, horseshoe | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3570 | Orthopedic shoe addition, special extension to instep (leather with eyelets) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3580 | Orthopedic shoe addition, convert instep to velcro closure | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3590 | Orthopedic shoe addition, convert firm shoe counter to soft counter | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3595 | Orthopedic shoe addition, march bar | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3600 | Transfer of an orthosis from one shoe to another, caliper plate, existing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3610 | Transfer of an orthosis from one shoe to another, caliper plate, new | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3620 | Transfer of an orthosis from one shoe to another, solid stirrup, existing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3630 | Transfer of an orthosis from one shoe to another, solid stirrup, new | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3640 | Transfer of an orthosis from one shoe to another, dennis browne splint (riveton), both shoes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| L3649 | Orthopedic shoe, modification, addition or transfer, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| L3649 | Orthopedic shoe, modification, addition or transfer, not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L3999 | Upper limb orthosis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 knee-knee 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 knee-knee 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 |

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

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

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

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

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L5827 | Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| 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 |

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

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

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| L5999 | Lower extremity prosthesis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| 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 |
| L6028 | Partial hand including fingers, flexible or non-flexible interface, endoskeletal system, molded to patient model, for use without external power, not including inserts described by l6692 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| L6029 | Upper extremity addition, test socket/interface, partial hand including fingers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L6030 | Upper extremity addition, external frame, partial hand including fingers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| L6031 | Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| L6032 | Addition to upper extremity prosthesis, partial hand including fingers, ultralight 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. | 4/1/2025 | 12/31/2999 |
| L6033 | Addition to upper extremity prosthesis, partial hand including fingers, acrylic material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| L6037 | Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, partial hand including fingers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| L6700 | Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| L6950 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L6955 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, 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 |
| L6960 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, 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 |
| L6965 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, 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 |
| L6970 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, 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 |
| L6975 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, 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 |
| 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| L7368 | LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L7406 | Addition to upper extremity, user adjustable, mechanical, residual limb volume management system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| L7499 | Upper extremity prosthesis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| L7900 | Male vacuum erection system | 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 |
| L7902 | Tension ring, for vacuum erection device, any type, replacement only, each | 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 |
| L8039 | Breast prosthesis, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| L8048 | Unspecified maxillofacial prosthesis, by report, provided by a non-physician | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| L8499 | Unlisted procedure for miscellaneous prosthetic services | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| L8603 | Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies | EIU: Procedure/service not 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 |
| L8605 | Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies | EIU: Procedure/service not 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 |
| L8606 | Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| L8699 | Prosthetic implant, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M0075 | Cellular therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M0100 | Intragastric hypothermia using gastric freezing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M1151 | Patients with a history of heart transplant or with a left ventricular assist device (lvad) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1152 | Patients with a history of heart transplant or with a left ventricular assist device (lvad) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1153 | Patient with diagnosis of osteoporosis on date of encounter | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1159 | Hospice services provided to patient any time during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1160 | Patient had anaphylaxis due to the meningococcal vaccine any time on or before the patient's 13th birthday | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1161 | Patient had anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1162 | Patient had encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1163 | Patient had anaphylaxis due to the hpv vaccine any time on or before the patient's 13th birthday | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1164 | Patients with dementia any time during the patient's history through the end of the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1165 | Patients who use hospice services any time during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1166 | Pathology report for tissue specimens produced from wide local excisions or re-excisions | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1167 | In hospice or using hospice services during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1168 | Patient received an influenza vaccine on or between july 1 of the year prior to the measurement period and june 30 of the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1169 | Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1170 | Patient did not receive an influenza vaccine on or between july 1 of the year prior to the measurement period and june 30 of the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1171 | Patient received at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1172 | Documentation of medical reason(s) for not administering td or tdap vaccine (e.g., prior anaphylaxis due to the td or tdap vaccine or history of encephalopathy within seven days after a previous dose of a td-containing vaccine) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1173 | Patient did not receive at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1174 | Patient received at least two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1175 | Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1176 | Patient did not receive two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1177 | 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M1178 | Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1179 | Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 19th birthday and before or during measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1180 | Patients on immune checkpoint inhibitor therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1181 | Grade 2 or above diarrhea and/or grade 2 or above colitis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1182 | Patients not eligible due to pre-existing inflammatory bowel disease (ibd) (e.g., ulcerative colitis, crohn's disease) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1183 | Documentation of immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1184 | Documentation of medical reason(s) for not prescribing or administering corticosteroid or immunosuppressant treatment (e.g., allergy, intolerance, infectious etiology, pancreatic insufficiency, hyperthyroidism, prior bowel surgical interventions, celiac disease, receiving other medication, awaiting diagnostic workup results for alternative etiologies, other medical reasons/contraindication) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1185 | Documentation of immune checkpoint inhibitor therapy not held and/or corticosteroids or immunosuppressants prescribed or administered was not performed, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1186 | Patients who have an order for or are receiving hospice or palliative care | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1187 | Patients with a diagnosis of end stage renal disease (esrd) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1188 | Patients with a diagnosis of chronic kidney disease (ckd) stage 5 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1189 | Documentation of a kidney health evaluation defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1190 | Documentation of a kidney health evaluation was not performed or defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M1199 | Patients receiving rrt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1200 | Ace inhibitor (ace-i) or arb therapy prescribed during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M1208 | Patient is not 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 pre-service review. | 1/1/2023 | 12/31/2999 |
| M1209 | At least two orders for high-risk medications from the same drug class, (table 4), without appropriate diagnoses | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1210 | At least two orders for high-risk medications from the same drug class, (table 4), not ordered | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2023 | 12/31/2999 |
| M1211 | Most recent glycemic status assessment (hba1c or gmi) level > 9.0% | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1212 | Glycemic status assessment (hba1c or gmi) level is missing, or was not performed during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1213 | No history of spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) and present spirometry is >= 70% | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1214 | Spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and reviewed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1215 | Documentation of medical reason(s) for not documenting and reviewing spirometry results (e.g., patients with dementia or tracheostomy) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1216 | No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed with results documented during the encounter | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1217 | Documentation of system reason(s) for not documenting and reviewing spirometry results (e.g., spirometry equipment not available at the time of the encounter) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1218 | Patient has copd symptoms (e.g., dyspnea, cough/sputum, wheezing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1220 | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; with evidence of retinopathy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1221 | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; without evidence of retinopathy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1222 | Glaucoma plan of care not documented, reason not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1223 | Glaucoma plan of care documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1224 | Intraocular pressure (iop) reduced by a value less than 20% from the pre-intervention level | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1225 | Intraocular pressure (iop) reduced by a value of greater than or equal to 20% from the pre-intervention level | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1226 | Iop measurement not documented, reason not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1227 | Evidence-based therapy was prescribed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1228 | Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, has hcv treatment initiated within 3 months of the reactive hcv antibody test | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1229 | Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, is referred within 1 month of the reactive hcv antibody test to a clinician who treats hcv infection | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1230 | Patient has a reactive hcv antibody test and does not have a follow up hcv viral test, or patient has a reactive hcv antibody test and has a follow up hcv viral test that detects hcv viremia and is not referred to a clinician who treats hcv infection within 1 month and does not have hcv treatment initiated within 3 months of the reactive hcv antibody test, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1231 | Patient receives hcv antibody test with nonreactive result | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1232 | Patient receives hcv antibody test with reactive result | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1233 | Patient does not receive hcv antibody test or patient does receive hcv antibody test but results not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1234 | Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1235 | Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1236 | Baseline mrs > 2 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1237 | Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1238 | Documentation that administration of second recombinant zoster vaccine could not occur during the performance period due to the recommended 2-6 month interval between doses (i.e, first dose received after october 31) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1239 | Patient did not respond to the question of patient felt heard and understood by this provider and team | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1240 | Patient did not respond to the question of patient felt this provider and team put my best interests first when making recommendations about my care | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1241 | Patient did not respond to the question of patient felt this provider and team saw me as a person, not just someone with a medical problem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1242 | Patient did not respond to the question of patient felt this provider and team understood what is important to me in my life | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1243 | Patient provided a response other than completely true for the question of patient felt heard and understood by this provider and team | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1244 | Patient provided a response other than completely true for the question of patient felt this provider and team put my best interests first when making recommendations about my care | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1245 | Patient provided a response other than completely true for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1246 | Patient provided a response other than completely true for the question of patient felt this provider and team understood what is important to me in my life | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1247 | Patient responded completely true for the question of patient felt this provider and team put my best interests first when making recommendations about my care | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1248 | Patient responded completely true for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1249 | Patient responded completely true for the question of patient felt this provider and team understood what is important to me in my life | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1250 | Patient responded as completely true for the question of patient felt heard and understood by this provider and team | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1251 | Patients for whom a proxy completed the entire hu survey on their behalf for any reason (no patient involvement) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1252 | Patients who did not complete at least one of the four patient experience hu survey items and return the hu survey within 60 days of the ambulatory palliative care visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1253 | Patients who respond on the patient experience hu survey that they did not receive care by the listed ambulatory palliative care provider in the last 60 days (disavowal) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1254 | Patients who were deceased when the hu survey reached them | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1255 | Patients who have another reason for visiting the clinic [not prenatal or postpartum care] and have a positive pregnancy test but have not established the clinic as an ob provider (e.g., plan to terminate the pregnancy or seek prenatal services elsewhere) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1256 | Prior history of known cvd | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1257 | Cvd risk assessment not performed or incomplete (e.g., cvd risk assessment was not documented), reason not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1258 | Cvd risk assessment performed, have a documented calculated risk score | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1259 | Patient status documented within the first year of initiating dialysis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1260 | Patient status not documented within the first year of initiating dialysis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1261 | Patients that were on the kidney or kidney-pancreas waitlist prior to initiation of dialysis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1262 | Patients who had a transplant prior to initiation of dialysis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1263 | Patients in hospice on their initiation of dialysis date or during the month of evaluation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1265 | Cms medical evidence form 2728 for dialysis patients: initial form completed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1266 | Patients admitted to a skilled nursing facility (snf) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1267 | Patients not observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1268 | Patients observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1269 | Receiving esrd mcp dialysis services by the provider on the last day of the reporting month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1270 | Patients not on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1271 | Patients with dementia at any time prior to or during the month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1272 | Patients observed on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1273 | Patients who were admitted to a skilled nursing facility (snf) within one year of dialysis initiation according to the cms-2728 form | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1274 | Patients who were admitted to a skilled nursing facility (snf) during the month of evaluation were excluded from that month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1275 | Patients determined to be in hospice were excluded from month of evaluation and the remainder of reporting period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1276 | Bmi documented outside normal parameters, no follow-up plan documented, no reason given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1277 | Colorectal cancer screening results documented and reviewed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1278 | Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1279 | Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1280 | Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1281 | Blood pressure reading not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1288 | Documented reason for not screening or recommending a follow-up for high blood pressure | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1289 | Patient identified as tobacco user did not receive tobacco cessation 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1291 | Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| M1310 | Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1316 | Current tobacco non-user | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1325 | Patients who were not seen for reasons documented by clinician for patient or medical reasons (e.g., inadequate time for follow-up, patients who received a prior intravitreal or periocular steroid injection within the last six (6) months and had a subsequent iop evaluation with iop <25mm hg within seven (7) weeks of treatment) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| M1337 | Acute pvd | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1338 | Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1339 | Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1340 | Index assessment completed using the 12-item whodas 2.0 or sds during the denominator identification period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1341 | Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1342 | Patients who died during the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1343 | Patients who are at pam level 4 at baseline or patients who are flagged with extreme straight line response sets on the pam or with excessive missing responses | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1344 | Patients who did not have a baseline pam score and/or a second score within 4 to 12 months of baseline pam score | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1345 | Patients who had a baseline pam score and a second score within 4 to 12 month of baseline pam score | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1346 | Patients who did not have a net increase in pam score of at least 6 points within a 4 to 12 month period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
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| M1347 | Patients who achieved a net increase in pam score of at least 3 points in a 4 to 12 month period (passing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1348 | Patients who achieved a net increase in pam score of at least 6-points in a 4 to 12 month period (excellent) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1358 | Patients who did not have 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1359 | Index assessment during the denominator period when the suicidal ideation and/or behavior symptoms or increased suicide risk by clinician determination occurs and a non-zero c-ssrs score is obtained | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1360 | Suicidal ideation and/or behavior symptoms based on the c-ssrs | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1361 | 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 pre-service review. | 1/1/2024 | 12/31/2999 |
| M1362 | Patients who died during the measurement period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1363 | Patients who did not have a follow-up assessment within 120 days of the index assessment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1364 | Calculated 10-year ascvd risk score of >= 20 percent during the performance period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| M1365 | Patient encounter during the performance period with hospice and palliative care specialty code 17 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1366 | Focusing on women's health mips value pathway | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1367 | Quality care for the treatment of ear, nose, and throat disorders mips value pathway | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1368 | Prevention and treatment of infectious disorders including hepatitis c and hiv mips value pathway | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1369 | Quality care in mental health and substance use disorders mips value pathway | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| M1370 | Rehabilitative support for musculoskeletal care mips value pathway | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| P2031 | Hair analysis (excluding arsenic) | 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 |
| P9020 | Platelet rich plasma, each unit | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| P9099 | Blood component or product not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2020 | 12/31/2999 |
| Q0035 | Cardiokymography | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| Q0114 | Fern test | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| Q0115 | Post-coital direct, qualitative examinations of vaginal or cervical mucous | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| Q0477 | Power module patient cable 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. | 1/1/2018 | 12/31/2999 |
| Q0478 | Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type | 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 |
| Q0479 | Power module for use with electric or electric/pneumatic ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | Effective Date | 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 | Effective Date | 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q0507 | MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013 | 12/31/2999 |
| Q0508 | MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013 | 12/31/2999 |
| Q0509 | MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 |
| Q2039 | Influenza virus vaccine, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 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 pre-service review. | 4/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q2050 | Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 pre-service 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 | Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive 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. | 1/1/2022 | 12/31/2999 |
| Q2056 | Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive 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. | 10/1/2022 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q2057 | Afamitresgene autoleucel, 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. | 4/1/2025 | 12/31/2999 |
| Q2058 | Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| Q4050 | Cast supplies, for unlisted types and materials of casts | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| Q4051 | Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| Q4082 | DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2007 | 12/31/2999 |
| 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 pre-service review. | 1/1/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q4100 | SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2009 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q4113 | GRAFTJACKET XPRESS, 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 |
| Q4114 | INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC | 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 |
| Q4115 | ALLOSKIN, 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 |
| Q4116 | ALLODERM, 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 |
| Q4117 | HYALOMATRIX, 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 | Ending Date |
|---|---|---|---|---|
| Q4118 | MATRISTEM MICROMATRIX, 1 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). | 5/15/2021 | 12/31/2999 |
| Q4121 | THERASKIN, PER SQUARE CENTIMETER | 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 |
| Q4122 | Dermacell, dermacell awm or dermacell awm porous, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2021 | 12/31/2999 |
| Q4123 | ALLOSKIN RT, 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 |
| Q4124 | OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4125 | ARTHROFLEX, 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 | Ending Date |
|---|---|---|---|---|
| Q4126 | Memoderm, dermaspan, tranzgraft or integuply, 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q4135 | Mediskin, 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 |
| Q4136 | Ez-derm, 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 |
| Q4137 | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter | 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 |
| Q4138 | Biodfence dryflex, 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 |
| Q4139 | Amniomatrix or biodmatrix, injectable, 1 cc | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| Q4140 | Biodfence, 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 |
| Q4141 | Alloskin ac, 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 |
| Q4142 | Xcm biologic tissue 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 |
| Q4143 | Repriza, 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 |
| Q4145 | Epifix, injectable, 1 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 |
| Q4146 | Tensix, 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 | Ending Date |
|---|---|---|---|---|
| Q4147 | Architect, architect px, or architect fx, extracellular 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 |
| Q4148 | Neox cord 1k, neox cord rt, or clarix cord 1k, 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 |
| Q4149 | Excellagen, 0.1 cc | EIU: Procedure/service not 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 |
| Q4150 | Allowrap ds or dry, 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 |
| Q4151 | Amnioband or guardian, 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 |
| Q4152 | Dermapure, 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 | Ending Date |
|---|---|---|---|---|
| Q4153 | Dermavest and plurivest, 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 |
| Q4154 | Biovance, 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 |
| Q4155 | Neoxflo or clarixflo, 1 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 |
| Q4156 | Neox 100 or clarix 100, 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 |
| Q4157 | Revitalon, 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 |
| Q4158 | Kerecis omega3, 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 | Ending Date |
|---|---|---|---|---|
| Q4159 | Affinity, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2022 | 12/31/2999 |
| Q4160 | Nushield, 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 |
| Q4161 | Bio-connekt wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4162 | Woundex flow, bioskin flow, 0.5 cc | EIU: Procedure/service not 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 |
| Q4163 | Woundex, bioskin, 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 |
| Q4164 | Helicoll, 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 | Ending Date |
|---|---|---|---|---|
| Q4165 | Keramatrix or kerasorb, 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 |
| Q4166 | Cytal, 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 |
| Q4167 | Truskin, 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 |
| Q4168 | Amnioband, 1 mg | 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 |
| Q4169 | Artacent wound, 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 |
| Q4170 | Cygnus, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4171 | Interfyl, 1 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 |
| Q4173 | Palingen or palingen xplus, 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 |
| Q4174 | Palingen or promatrx, 0.36 mg per 0.25 cc | EIU: Procedure/service not 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 |
| Q4175 | Miroderm, 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). | 4/1/2021 | 12/31/2999 |
| Q4176 | Neopatch or therion, 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 |
| Q4177 | Floweramnioflo, 0.1 cc | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| Q4178 | Floweramniopatch, 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 |
| Q4179 | Flowerderm, 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 |
| Q4180 | Revita, 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 |
| Q4181 | Amnio wound, 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 |
| Q4182 | Transcyte, 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 |
| Q4183 | Surgigraft, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4184 | Cellesta or cellesta duo, 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 |
| Q4185 | Cellesta flowable amnion (25 mg per cc); per 0.5 cc | EIU: Procedure/service not 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 |
| Q4186 | Epifix, per square centimeter | 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 |
| Q4187 | Epicord, per square centimeter | 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 |
| Q4188 | Amnioarmor, 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 |
| Q4189 | Artacent ac, 1 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 | Ending Date |
|---|---|---|---|---|
| Q4190 | Artacent ac, 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 |
| Q4191 | Restorigin, 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 |
| Q4192 | Restorigin, 1 cc | EIU: Procedure/service not 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 |
| Q4193 | Coll-e-derm, 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 |
| Q4194 | Novachor, 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 |
| Q4195 | Puraply, 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 | Ending Date |
|---|---|---|---|---|
| Q4196 | Puraply am, 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 |
| Q4197 | Puraply xt, 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 |
| Q4198 | Genesis amniotic membrane, 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 |
| Q4199 | Cygnus 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). | 4/15/2022 | 12/31/2999 |
| Q4200 | Skin te, 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 |
| Q4201 | Matrion, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4202 | Keroxx (2.5g/cc), 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 |
| Q4203 | Derma-gide, 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 |
| Q4204 | Xwrap, 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 |
| Q4205 | Membrane graft or 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). | 12/1/2020 | 12/31/2999 |
| Q4206 | Fluid flow or fluid GF, 1 cc | EIU: Procedure/service not 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 |
| Q4208 | Novafix, per square cenitmeter | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| Q4209 | Surgraft, 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 |
| Q4211 | Amnion bio or Axobiomembrane, 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 |
| Q4212 | Allogen, per cc | EIU: Procedure/service not 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 |
| Q4213 | Ascent, 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 |
| Q4214 | Cellesta cord, 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 |
| Q4215 | Axolotl ambient or axolotl cryo, 0.1 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 | Ending Date |
|---|---|---|---|---|
| Q4216 | Artacent cord, 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 |
| Q4217 | Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, 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 |
| Q4218 | Surgicord, 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 |
| Q4219 | Surgigraft-dual, 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 |
| Q4220 | BellaCell HD or Surederm, 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 |
| Q4221 | Amniowrap2, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4222 | Progenamatrix, 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 |
| Q4224 | Human health factor 10 amniotic patch (hhf10-p), 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). | 4/1/2022 | 12/31/2999 |
| Q4225 | Amniobind or dermabind tl, 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). | 4/1/2022 | 12/31/2999 |
| Q4226 | MyOwn skin, includes harvesting and preparation procedures, 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). | 10/1/2024 | 12/31/2999 |
| Q4227 | Amniocore, 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 |
| Q4229 | Cogenex amniotic membrane, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4230 | Cogenex flowable amnion, per 0.5 cc | EIU: Procedure/service not 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 |
| Q4231 | Corplex p, per cc | EIU: Procedure/service not 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 | 3/31/2025 |
| Q4232 | Corplex, 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 |
| Q4233 | Surfactor or nudyn, per 0.5 cc | EIU: Procedure/service not 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 |
| Q4234 | Xcellerate, 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 |
| Q4235 | Amniorepair or altiply, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4236 | Carepatch, 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 |
| Q4237 | Cryo-cord, 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 |
| Q4238 | Derm-maxx, 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). | 7/1/2022 | 12/31/2999 |
| Q4239 | Amnio-maxx or amnio-maxx lite, 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 |
| Q4240 | Corecyte, for topical use only, per 0.5 cc | EIU: Procedure/service not 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 |
| Q4241 | Polycyte, for topical use only, per 0.5 cc | EIU: Procedure/service not 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 | Ending Date |
|---|---|---|---|---|
| Q4242 | Amniocyte plus, per 0.5 cc | EIU: Procedure/service not 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 |
| Q4245 | Amniotext, per cc | EIU: Procedure/service not 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 |
| Q4246 | Coretext or protext, per cc | EIU: Procedure/service not 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 |
| Q4247 | Amniotext patch, 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 |
| Q4248 | Dermacyte 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). | 12/1/2020 | 12/31/2999 |
| Q4249 | Amniply, for topical use only, 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). | 3/1/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4250 | Amnioamp-mp, 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). | 3/1/2021 | 12/31/2999 |
| Q4251 | Vim, 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). | 4/15/2022 | 12/31/2999 |
| Q4252 | Vendaje, 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). | 4/15/2022 | 12/31/2999 |
| Q4253 | Zenith amniotic membrane, 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). | 4/15/2022 | 12/31/2999 |
| Q4254 | Novafix dl, 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). | 3/1/2021 | 12/31/2999 |
| Q4255 | Reguard, for topical use only, 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). | 3/1/2021 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4256 | Mlg-complete, 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). | 4/1/2022 | 12/31/2999 |
| Q4257 | Relese, 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). | 4/1/2022 | 12/31/2999 |
| Q4258 | Enverse, 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). | 4/1/2022 | 12/31/2999 |
| Q4259 | Celera dual layer or celera dual membrane, 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). | 1/1/2023 | 12/31/2999 |
| Q4260 | Signature apatch, 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). | 1/1/2023 | 12/31/2999 |
| Q4261 | Tag, 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). | 1/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4262 | Dual layer impax membrane, per square centimeter | 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 |
| Q4263 | Surgraft tl, per square centimeter | 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 |
| Q4264 | Cocoon membrane, per square centimeter | 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 |
| Q4265 | Neostim tl, 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). | 9/1/2023 | 12/31/2999 |
| Q4266 | Neostim membrane, 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). | 9/1/2023 | 12/31/2999 |
| Q4267 | Neostim dl, 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). | 9/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4268 | Surgraft ft, 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). | 9/1/2023 | 12/31/2999 |
| Q4269 | Surgraft xt, 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). | 9/1/2023 | 12/31/2999 |
| Q4270 | Complete sl, 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). | 9/1/2023 | 12/31/2999 |
| Q4271 | Complete ft, 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). | 9/1/2023 | 12/31/2999 |
| Q4272 | Esano a, 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). | 12/1/2023 | 12/31/2999 |
| Q4273 | Esano aaa, 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). | 12/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4274 | Esano ac, 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). | 12/1/2023 | 12/31/2999 |
| Q4275 | Esano aca, 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). | 12/1/2023 | 12/31/2999 |
| Q4276 | Orion, 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). | 12/1/2023 | 12/31/2999 |
| Q4278 | Epieffect, 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). | 12/1/2023 | 12/31/2999 |
| Q4279 | Vendaje ac, 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). | 7/1/2024 | 12/31/2999 |
| Q4280 | Xcell amnio 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). | 12/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4281 | Barrera sl or barrera dl, 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). | 12/1/2023 | 12/31/2999 |
| Q4282 | Cygnus dual, 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). | 12/1/2023 | 12/31/2999 |
| Q4283 | Biovance tri-layer or biovance 3l, per square centimeter | 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 |
| Q4283 | Biovance tri-layer or biovance 3l, 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). | 12/1/2023 | 12/31/2999 |
| Q4284 | Dermabind sl, 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). | 12/1/2023 | 12/31/2999 |
| Q4285 | Nudyn dl or nudyn dl mesh, 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). | 10/1/2023 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4286 | Nudyn sl or nudyn slw, 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). | 10/1/2023 | 12/31/2999 |
| Q4287 | Dermabind dl, 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). | 7/1/2024 | 12/31/2999 |
| Q4288 | Dermabind ch, 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). | 7/1/2024 | 12/31/2999 |
| Q4289 | Revoshield + amniotic barrier, 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). | 7/1/2024 | 12/31/2999 |
| Q4290 | Membrane wrap-hydro, 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). | 7/1/2024 | 12/31/2999 |
| Q4291 | Lamellas xt, 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4292 | Lamellas, 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). | 7/1/2024 | 12/31/2999 |
| Q4293 | Acesso dl, 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). | 7/1/2024 | 12/31/2999 |
| Q4294 | Amnio quad-core, 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). | 7/1/2024 | 12/31/2999 |
| Q4295 | Amnio tri-core amniotic, 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). | 7/1/2024 | 12/31/2999 |
| Q4296 | Rebound 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). | 7/1/2024 | 12/31/2999 |
| Q4297 | Emerge 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4298 | Amnicore pro, 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). | 7/1/2024 | 12/31/2999 |
| Q4299 | Amnicore pro+, 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). | 7/1/2024 | 12/31/2999 |
| Q4300 | Acesso tl, 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). | 7/1/2024 | 12/31/2999 |
| Q4301 | Activate 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). | 7/1/2024 | 12/31/2999 |
| Q4302 | Complete aca, 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). | 7/1/2024 | 12/31/2999 |
| Q4303 | Complete aa, 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4304 | Grafix plus, per square centimeter | 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 |
| Q4305 | American amnion ac tri-layer, 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). | 4/1/2024 | 12/31/2999 |
| Q4306 | American amnion ac, 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). | 4/1/2024 | 12/31/2999 |
| Q4307 | American amnion, 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). | 4/1/2024 | 12/31/2999 |
| Q4308 | Sanopellis, 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). | 4/1/2024 | 12/31/2999 |
| Q4309 | Via 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). | 4/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4310 | Procenta, per 100 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 |
| Q4311 | Acesso, 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). | 7/1/2024 | 12/31/2999 |
| Q4312 | Acesso ac, 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). | 7/1/2024 | 12/31/2999 |
| Q4313 | Dermabind fm, 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). | 7/1/2024 | 12/31/2999 |
| Q4314 | Reeva ft, per square cenitmeter | EIU: Procedure/service not 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 |
| Q4315 | Regenelink 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4316 | Amchoplast, 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). | 7/1/2024 | 12/31/2999 |
| Q4317 | Vitograft, 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). | 7/1/2024 | 12/31/2999 |
| Q4318 | E-graft, 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). | 7/1/2024 | 12/31/2999 |
| Q4319 | Sanograft, 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). | 7/1/2024 | 12/31/2999 |
| Q4320 | Pellograft, 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). | 7/1/2024 | 12/31/2999 |
| Q4321 | Renograft, 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4322 | Caregraft, 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). | 7/1/2024 | 12/31/2999 |
| Q4323 | Alloply, 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). | 7/1/2024 | 12/31/2999 |
| Q4324 | Amniotx, 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). | 7/1/2024 | 12/31/2999 |
| Q4325 | Acapatch, 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). | 7/1/2024 | 12/31/2999 |
| Q4326 | Woundplus, 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). | 7/1/2024 | 12/31/2999 |
| Q4327 | Duoamnion, 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4328 | Most, 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). | 7/1/2024 | 12/31/2999 |
| Q4329 | Singlay, 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). | 7/1/2024 | 12/31/2999 |
| Q4330 | Total, 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). | 7/1/2024 | 12/31/2999 |
| Q4331 | Axolotl graft, 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). | 7/1/2024 | 12/31/2999 |
| Q4332 | Axolotl dualgraft, 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). | 7/1/2024 | 12/31/2999 |
| Q4333 | Ardeograft, 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). | 7/1/2024 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4334 | Amnioplast 1, 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 |
| Q4334 | Amnioplast 1, 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 |
| Q4335 | Amnioplast 2, 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 |
| Q4335 | Amnioplast 2, 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 |
| Q4336 | Artacent c, 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 |
| Q4336 | Artacent c, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4337 | Artacent trident, 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 |
| Q4337 | Artacent trident, 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 |
| Q4338 | Artacent velos, 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 |
| Q4338 | Artacent velos, 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 |
| Q4339 | Artacent vericlen, 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 |
| Q4339 | Artacent vericlen, 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4340 | Simpligraft, 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 |
| 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| Q4346 | Shelter dm 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). | 6/15/2025 | 12/31/2999 |
| 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 | 6/14/2025 |
| Q4347 | Rampart dl 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). | 6/15/2025 | 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 | 6/14/2025 |
| Q4348 | Sentry sl 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). | 6/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| Q4349 | Mantle dl 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). | 6/15/2025 | 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 | 6/14/2025 |
| Q4350 | Palisade dm 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). | 6/15/2025 | 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 | 6/14/2025 |
| Q4351 | Enclose tl 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). | 6/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 6/14/2025 |
| Q4352 | Overlay sl 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). | 6/15/2025 | 12/31/2999 |
| 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 | 6/14/2025 |
| Q4353 | Xceed tl 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). | 6/15/2025 | 12/31/2999 |
| Q4354 | Palingen dual-layer membrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4354 | Palingen dual-layer membrane, 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4355 | Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4355 | Abiomend xplus membrane and abiomend xplus hydromembrane, 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). | 9/15/2025 | 12/31/2999 |
| Q4356 | Abiomend membrane and abiomend hydromembrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4356 | Abiomend membrane and abiomend hydromembrane, 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). | 9/15/2025 | 12/31/2999 |
| Q4357 | Xwrap plus, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4357 | Xwrap plus, 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4358 | Xwrap dual, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4358 | Xwrap dual, 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). | 9/15/2025 | 12/31/2999 |
| Q4359 | Choriply, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4359 | Choriply, 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). | 9/15/2025 | 12/31/2999 |
| Q4360 | Amchoplast fd, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4360 | Amchoplast fd, 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4361 | Epixpress, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4361 | Epixpress, 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). | 9/15/2025 | 12/31/2999 |
| Q4362 | Cygnus disk, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4362 | Cygnus disk, 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). | 9/15/2025 | 12/31/2999 |
| Q4363 | Amnio burgeon membrane and hydromembrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4363 | Amnio burgeon membrane and hydromembrane, 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4364 | Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4364 | Amnio burgeon xplus membrane and xplus hydromembrane, 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). | 9/15/2025 | 12/31/2999 |
| Q4365 | Amnio burgeon dual-layer membrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4365 | Amnio burgeon dual-layer membrane, 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). | 9/15/2025 | 12/31/2999 |
| Q4366 | Dual layer amnio burgeon x-membrane, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4366 | Dual layer amnio burgeon x-membrane, 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). | 9/15/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4367 | Amniocore sl, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 9/14/2025 |
| Q4367 | Amniocore sl, 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). | 9/15/2025 | 12/31/2999 |
| Q4368 | Amchothick, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4369 | Amnioplast 3, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4370 | Aeroguard, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4371 | Neoguard, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4372 | Amchoplast excel, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4373 | Membrane wrap lite, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4375 | Duograft ac, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4376 | Duograft aa, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4377 | Trigraft ft, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4378 | Renew ft matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q4379 | Amniodefend ft matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4380 | Advograft one, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q4382 | Advograft dual, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q5009 | Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2007 | 12/31/2999 |
| Q5098 | Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| Q5099 | Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q5100 | Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 9/30/2025 |
| 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q5147 | Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| Q5148 | Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| Q5149 | Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| Q5150 | Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| Q5151 | Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| Q5152 | Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| Q5153 | Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2025 | 12/31/2999 |
| Q9004 | Department of veterans affairs whole health partner services | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| Q9998 | Injection, ustekinumab-aekn (selarsdi), biosimilar, 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 |
| Q9999 | Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S0128 | Injection, follitropin beta, 75 iu | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |
| 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 pre-service 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 pre-service 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 pre-service 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 | 5/31/2025 |
| S0510 | Non-prescription lens (safety, athletic, or sunglass), per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S0516 | Safety eyeglass frames | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S0518 | Sunglasses frames | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S0590 | Integral lens service, miscellaneous services reported separately | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 pre-service 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 |
| S0810 | Photorefractive keratectomy (prk) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S1001 | Deluxe item, patient aware (list in addition to code for basic item) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S1002 | Customized item (list in addition to code for basic item) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |
| 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 |

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

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

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| 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 |
| S2409 | Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 |
| S3655 | Antisperm antibodies test (immunobead) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 |
| S3900 | 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 pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S4015 | Complete in vitro fertilization cycle, not otherwise specified, case rate | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S4018 | Frozen embryo transfer procedure cancelled before transfer, case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4020 | In vitro fertilization procedure cancelled before aspiration, case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S4021 | In vitro fertilization procedure cancelled after aspiration, case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4022 | Assisted oocyte fertilization, case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4023 | Donor egg cycle, incomplete, case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4024 | Air polymer-type a intrauterine foam, per study dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025 | 12/31/2999 |
| S4025 | Donor services for in vitro fertilization (sperm or embryo), case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4026 | Procurement of donor sperm from sperm bank | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4027 | Storage of previously frozen embryos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4028 | Microsurgical epididymal sperm aspiration (mesa) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4030 | Sperm procurement and cryopreservation services; initial visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4031 | Sperm procurement and cryopreservation services; subsequent visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S4035 | Stimulated intrauterine insemination (iui), case rate | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S4991 | Nicotine patches, non-legend | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4995 | Smoking cessation gum | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5100 | Day care services, adult; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S5101 | Day care services, adult; per half day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5102 | Day care services, adult; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5105 | Day care services, center-based; services not included in program fee, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5108 | Home care training to home care client, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5109 | Home care training to home care client, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5110 | Home care training, family; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5111 | Home care training, family; per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5115 | Home care training, non-family; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5116 | Home care training, non-family; per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5120 | Chore services; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S5121 | Chore services; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5125 | Attendant care services; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5126 | Attendant care services; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5130 | Homemaker service, nos; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S5130 | Homemaker service, nos; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5131 | Homemaker service, nos; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S5131 | Homemaker service, nos; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5135 | Companion care, adult (e. G. Iadl/adl); per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5136 | Companion care, adult (e. G. Iadl/adl); per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S5140 | Foster care, adult; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5141 | Foster care, adult; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5145 | Foster care, therapeutic, child; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5146 | Foster care, therapeutic, child; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5150 | Unskilled respite care, not hospice; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5151 | Unskilled respite care, not hospice; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5160 | Emergency response system; installation and testing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5161 | Emergency response system; service fee, per month (excludes installation and testing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5162 | Emergency response system; purchase only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5165 | Home modifications; per service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S5170 | Home delivered meals, including preparation; per meal | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5175 | Laundry service, external, professional; per order | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5181 | Home health respiratory therapy, nos, per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| S5185 | Medication reminder service, non-face-to-face; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5199 | Personal care item, nos, each | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S5199 | Personal care item, nos, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5497 | Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| S8035 | Magnetic source imaging | 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 | Ending Date |
|---|---|---|---|---|
| S8040 | 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 |
| S8131 | 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 |
| S8189 | Tracheostomy supply, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S8270 | Enuresis alarm, using auditory buzzer and/or vibration device | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2005 | 12/31/2999 |
| S8301 | Infection control supplies, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 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 |
| 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 | 6/30/2025 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 5/31/2025 |
| 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 |
| 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 | 5/31/2025 |
| 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 | 5/31/2025 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S9125 | Respite care, in the home, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 |
| S9341 | Home therapy; enteral nutrition via gravity; 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 |
| S9342 | Home therapy; enteral nutrition via pump; 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 | Ending Date |
|---|---|---|---|---|
| S9343 | Home therapy; enteral nutrition via bolus; 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. | 7/27/2009 | 12/31/2999 |
| S9355 | Home infusion therapy, chelation therapy; 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. | 10/15/2007 | 12/31/2999 |
| S9364 | Home infusion therapy, total parenteral nutrition (tpn); 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 (do not use with home infusion codes s9365-s9368 using daily volume scales) | 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 |
| 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 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 |
| S9368 | Home infusion therapy, total parenteral nutrition (tpn); 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 | 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 |
| S9379 | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S9381 | Delivery or service to high risk areas requiring escort or extra protection, per visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9401 | Anticoagulation clinic, inclusive of all services except laboratory tests, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 | Effective Date | Ending Date |
|---|---|---|---|---|
| S9432 | Medical foods for non-inborn errors of metabolism | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S9435 | 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S9445 | Patient education, not otherwise classified, non-physician provider, individual, per session | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S9445 | Patient education, not otherwise classified, non-physician provider, individual, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9446 | Patient education, not otherwise classified, non-physician provider, group, per session | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| S9449 | Weight management classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9451 | Exercise classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9454 | Stress management classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S9472 | Cardiac rehabilitation program, non-physician provider, per diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| S9473 | Pulmonary rehabilitation program, non-physician provider, per diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2008 | 12/31/2999 |
| S9482 | FAMILY STABILIZATION SERVICES, PER 15 MINUTES | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| S9537 | 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. | 1/1/2011 | 12/31/2999 |
| S9542 | Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 | 9/30/2025 |
| 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 |
| 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) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| S9900 | SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9960 | Ambulance service, conventional air services, nonemergency transport, one way (fixed wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| S9961 | Ambulance service, conventional air service, nonemergency transport, one way (rotary wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| S9970 | Health club membership, annual | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S9976 | Lodging, per diem, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S9976 | Lodging, per diem, not otherwise classified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9977 | Meals, per diem, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| S9977 | Meals, per diem, not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9981 | Medical records copying fee, administrative | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9982 | Medical records copying fee, per page | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9986 | Not medically necessary service (patient is aware that service not medically necessary) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9988 | Services provided as part of a phase i clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9989 | Services provided outside of the united states of america (list in addition to code(s) for services(s)) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| S9990 | Services provided as part of a phase ii clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9991 | Services provided as part of a phase iii clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9992 | Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9994 | Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9996 | Meals for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9999 | Sales tax | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 6/1/2014 | 12/31/2999 |
| T1005 | Respite care services, up to 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1006 | Alcohol and/or substance abuse services, family/couple counseling | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1009 | Child sitting services for children of the individual receiving alcohol and/or substance abuse services | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1010 | Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T1012 | Alcohol and/or substance abuse services, skills development | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1013 | Sign language or oral interpretive services, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1014 | Telehealth transmission, per minute, professional services bill separately | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T1018 | School-based individualized education program (iep) services, bundled | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 10/1/2022 | 12/31/2999 |
| T1505 | ELECTRONIC MEDICATION COMPLIANCE MANAGEMENT DEVICE, INCLUDES ALL COMPONENTS AND ACCESSORIES, NOT OTHERWISE CLASSIFIED | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T1999 | Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| T2001 | Non-emergency transportation; patient attendant/escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2002 | Non-emergency transportation; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| T2012 | Habilitation, educational; waiver, per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2012 | Habilitation, educational; waiver, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2013 | Habilitation, educational, waiver; per hour | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2013 | Habilitation, educational, waiver; per hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2014 | Habilitation, prevocational, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2014 | Habilitation, prevocational, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2015 | Habilitation, prevocational, waiver; per hour | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2015 | Habilitation, prevocational, waiver; per hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2016 | Habilitation, residential, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2016 | Habilitation, residential, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2017 | Habilitation, residential, waiver; 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2017 | Habilitation, residential, waiver; 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2018 | Habilitation, supported employment, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2018 | Habilitation, supported employment, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2019 | Habilitation, supported employment, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2019 | Habilitation, supported employment, waiver; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2020 | Day habilitation, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2020 | Day habilitation, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2021 | Day habilitation, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2021 | Day habilitation, waiver; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2024 | Service assessment/plan of care development, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2025 | Waiver services; not otherwise specified (nos) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2026 | Specialized childcare, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2026 | Specialized childcare, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2027 | Specialized childcare, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2027 | Specialized childcare, waiver; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2028 | Specialized supply, not otherwise specified, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2028 | Specialized supply, not otherwise specified, waiver | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2029 | Specialized medical equipment, not otherwise specified, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| T2029 | Specialized medical equipment, not otherwise specified, waiver | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2030 | Assisted living, waiver; per month | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2031 | Assisted living; waiver, per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2032 | Residential care, not otherwise specified (nos), waiver; per month | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2033 | Residential care, not otherwise specified (nos), waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2034 | Crisis intervention, waiver; per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2034 | Crisis intervention, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2035 | Utility services to support medical equipment and assistive technology/devices, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2035 | Utility services to support medical equipment and assistive technology/devices, waiver | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2036 | Therapeutic camping, overnight, waiver; each session | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2036 | Therapeutic camping, overnight, waiver; each session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2037 | Therapeutic camping, day, waiver; each session | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2037 | Therapeutic camping, day, waiver; each session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2038 | Community transition, waiver; per service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2038 | Community transition, waiver; per service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2039 | Vehicle modifications, waiver; per service | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2039 | Vehicle modifications, waiver; per service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2040 | Financial management, self-directed, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T2040 | Financial management, self-directed, waiver; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2041 | Supports brokerage, self-directed, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| T2041 | Supports brokerage, self-directed, waiver; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T2049 | NON-EMERGENCY TRANSPORTATION; STRETCHER VAN, MILEAGE; PER MILE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2004 | 12/31/2999 |
| T2050 | Financial management, self-directed, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2022 | 12/31/2999 |
| T2051 | Supports brokerage, self-directed, waiver; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2022 | 12/31/2999 |
| T2101 | Human breast milk processing, storage and distribution only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T4521 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4522 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4523 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T4524 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4525 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4526 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4527 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4528 | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4529 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4530 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4531 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4532 | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4533 | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T4534 | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4535 | DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4536 | INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, REUSABLE, ANY SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4537 | INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, BED SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4538 | DIAPER SERVICE, REUSABLE DIAPER, EACH DIAPER | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| T4539 | INCONTINENCE PRODUCT, DIAPER/BRIEF, REUSABLE, ANY SIZE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service 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 pre-service 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 pre-service 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 pre-service review. | 1/1/2007 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| T5001 | POSITIONING SEAT FOR PERSONS WITH SPECIAL ORTHOPEDIC NEEDS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| T5999 | Supply, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008 | 12/31/2999 |
| V2199 | Not otherwise classified, single vision lens | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| V2599 | Contact lens, other type | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 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 |
| V2629 | Prosthetic eye, other type | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| V2702 | DELUXE LENS FEATURE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| V2756 | Eye glass case | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 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 pre-service 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 pre-service 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 pre-service 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 pre-service 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 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| V2799 | Vision item or service, miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| V5090 | Dispensing fee, unspecified hearing aid | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| 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 |
| V5267 | Hearing aid or assistive listening device/supplies/accessories, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |
| V5269 | Assistive listening device, alerting, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| V5270 | Assistive listening device, television amplifier, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| V5272 | Assistive listening device, tdd | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| V5274 | Assistive listening device, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 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 pre-service review. | 1/1/1950 | 12/31/2999 |
| V5287 | Assistive listening device, personal fm/dm receiver, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019 | 12/31/2999 |
| V5298 | Hearing aid, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

| Procedure Code | Code Description | Code Group & Description | Effective Date | Ending Date |
|---|---|---|---|---|
| V5299 | Hearing service, miscellaneous | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950 | 12/31/2999 |

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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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