BlueCross BlueShield of Oklahoma

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

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding Systemcodes that, based on our medical policy, are: **- Subject to a medical necessity review,** **- Candidates for a Recommended Clinical Review,** **- Not a benefit for our members,** **- Considered experimental, investigational and unproven (EIU), or** **- Not on our prior authorization list (with some exceptions based on members' benefit plans)** **Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025.**	**Utilization Management Process** **This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.**

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.
	Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
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

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	12/31/2999
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
11719	Trimming of nondystrophic nails, any number	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2007	12/31/2999

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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15776	Punch graft for hair transplant; more than 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15879	Suction assisted lipectomy; lower extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
17360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
17380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
29916	Arthroscopy, hip, surgical; with labral repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
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
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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
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
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36511	Therapeutic apheresis; for white blood cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2003	12/31/2999
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	1/14/2025

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
37788	Penile revascularization, artery, with or without vein graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2007	12/31/2999

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2009	12/31/2999
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
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	12/31/2999
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
53865	Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
53866	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
55400	Vasovasostomy, vasovasorrhaphy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
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	12/31/2999
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2008	12/31/2999

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
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
65785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/5/2018	12/31/2999
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2019	12/31/2999
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
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
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	12/31/2999

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	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
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
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
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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2022	12/31/2999
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2022	12/31/2999
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
95919	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
95957	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
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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0063U	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	EIU: Procedure/service not 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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day);	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0312U	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
0323U	Infectious agent detection by nucleic acid (DNA and RNA), central nervous system pathogen, metagenomic next-generation sequencing, cerebrospinal fluid (CSF), identification of pathogenic bacteria, viruses, parasites, or fungi	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0335T	Insertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential CD138, CD38, CD19, and CD45 protein biomarker expression, peripheral blood	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0342U	Oncology (pancreatic cancer), multiplex immunoassay of C5, C4, cystatin C, factor B, osteoprotegerin (OPG), gelsolin, IGFBP3, CA125 and multiplex electrochemiluminescent immunoassay (ECLIA) for CA19-9, serum, diagnostic algorithm reported qualitatively as positive, negative, or borderline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0345T	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0353T	Optical coherence tomography of breast, surgical cavity; real-time intraoperative	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	6/30/2025

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk	Non Covered: Procedure/service not covered by the Plan. Not subject to 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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
0449U	Carrier screening for severe inherited conditions (eg, cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia), regardless of race or self-identified ancestry, genomic sequence analysis panel, must include analysis of 5 genes (CFTR, SMN1, HBB, HBA1, HBA2)	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2022	12/31/2999
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2022	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer	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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0510T	Removal of sinus tarsi implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	12/31/2999
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2019	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0529U	Hematology (venous thromboembolism [VTE]), genome-wide single-nucleotide polymorphism variants, including F2 and F5 gene analysis, and Leiden variant, by microarray analysis, saliva, report as risk score for VTE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	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
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2024	12/31/2999
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0572T	Insertion of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0573T	Removal of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
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
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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
A2027	Matriderm, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
A2027	Matriderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A2028	Micromatrix flex, per mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
A2028	Micromatrix flex, per mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	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	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	12/31/2999
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	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	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	12/31/2999
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
A4575	Topical hyperbaric oxygen chamber, disposable	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A9150	Non-prescription drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to 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	6/14/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9268	Programmer for transient, orally ingested capsule	EIU: Procedure/service not 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
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	6/14/2025
A9269	Programable, transient, orally ingested capsule, for use with external programmer, 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).	6/15/2025	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
A9582	IODINE I-123 IOBENGUANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2013	12/31/2999
A9588	Fluciclovine f-18, diagnostic, 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
A9602	Fluorodopa f-18, diagnostic, per millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
A9608	Flotufolastat f 18, diagnostic, 1 millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
A9609	Fludeoxyglucose f18 up to 15 millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) homemix per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
B4220	Parenteral nutrition supply kit; premix, per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
B4222	Parenteral nutrition supply kit; home mix, per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
B4224	Parenteral nutrition administration kit, per day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
B5000	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1787	Patient programmer, neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/5/2018	12/31/2999
C1816	Receiver and/or transmitter, neurostimulator (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/5/2018	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	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	12/31/2999
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	12/31/2999
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	12/31/2999
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	12/31/2999
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
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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0629	Seat lift mechanism, non-electric, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2010	12/31/2999
E0635	Patient lift, electric with seat or sling	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0636	Multipositional patient support system, with integrated lift, patient accessible controls	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2004	12/31/2999
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0640	Patient lift, fixed system, includes all components/accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0641	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
E0650	Pneumatic compressor, non-segmental home model	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2015	12/31/2999
E0671	Segmental gradient pressure pneumatic appliance, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0672	Segmental gradient pressure pneumatic appliance, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0673	Segmental gradient pressure pneumatic appliance, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2008	12/31/2999
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
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
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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended 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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2007	12/31/2999
E0787	External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
E0830	Ambulatory traction device, all types, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0935	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
E0941	Gravity assisted traction device, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E0969	Narrowing device, wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0981	Wheelchair accessory, seat upholstery, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E0982	Wheelchair accessory, back upholstery, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0985	Wheelchair accessory, seat lift mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0986	Manual wheelchair accessory, push-rim activated power assist system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1005	Wheelchair accessory, power seatng system, recline only, with power shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1290	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E1296	Special wheelchair seat height from floor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1297	Special wheelchair seat depth, by upholstery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2324	Power wheelchair accessory, chin cup for chin control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended 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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
E2360	Power wheelchair accessory, 22 nf non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2361	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2364	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2365	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2006	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	12/31/2999
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

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
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	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. ++	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
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	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2025	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
G8451	Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8452	Beta-blocker therapy not prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8474	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8478	Blood pressure measurement not performed or documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0175	Injection, donanemab-azbt, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/2/2024	12/31/2999
J0177	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J0178	Injection, aflibercept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
J0179	Injection, brolucizumab-dbll, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0470	Injection, dimercaprol, per 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
J0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
J0895	Injection, deferoxamine mesylate, 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2007	12/31/2999
J1071	Injection, testosterone cypionate, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	12/31/2999
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1811	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1812	Insulin (fiasp), per 5 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1813	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1814	Insulin (lyumjev), per 5 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1930	INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
J1932	Injection, lanreotide, (cipla), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2024	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	12/31/2999
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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7642	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7643	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	EIU: Procedure/service not reimbursed 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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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
J9274	Injection, tebentafusp-tebn, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to 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
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
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0003	Lightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
K0004	High strength, lightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
K0005	Ultralightweight wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2011	12/31/2999
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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
K1034	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2007	12/31/2999
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2024	12/31/2999
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2015	12/31/2999
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
L5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2019	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
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
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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1234	Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1235	Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1236	Baseline mrs > 2	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1237	Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1238	Documentation that administration of second recombinant zoster vaccine could not occur during the performance period due to the recommended 2-6 month interval between doses (i.e, first dose received after october 31)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1239	Patient did not respond to the question of patient felt heard and understood by this provider and team	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
M1240	Patient did not respond to the question of patient felt this provider and team put my best interests first when making recommendations about my care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
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
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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0488	Power pack base for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0490	Emergency power source for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended 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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2018	12/31/2999
Q4134	Hmatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4341	Simplimax, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4341	Simplimax, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4342	Theramend, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4342	Theramend, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4344	Tri-membrane wrap, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4344	Tri-membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4345	Matrix hd allograft dermis, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
Q4345	Matrix hd allograft dermis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4346	Shelter dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
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	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	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	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	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	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	12/31/2999
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	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	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	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	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	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	12/31/2999
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	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
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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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
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	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S1035	Sensor; invasive (eg, subcutaneous), disposable, for use with artificial pancreas device system, 1 unit = 1 day supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
S1036	Transmitter; external, for use with artificial pancreas device system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2004	12/31/2999
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2008	12/31/2999
S2102	Islet cell tissue transplant from pancreas; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S2103	Adrenal tissue transplant to brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S2107	Adoptive immunotherapy i. E. Development of specific anti-tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	12/31/2999
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
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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	12/31/2999
S9090	Vertebral axial decompression, per session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2999
S9117	Back school, per visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
S9125	Respite care, in the home, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to 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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9366	Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/14/2009	12/31/2999
S9367	Home infusion therapy, total parenteral nutrition (tpn); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9451	Exercise classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9454	Stress management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9472	Cardiac rehabilitation program, non-physician provider, per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S9473	Pulmonary rehabilitation program, non-physician provider, per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2008	12/31/2999
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
S9537	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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2015	12/31/2999
S9562	Home injectable therapy, palivizumab or other monoclonal antibody for rsv, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/27/2009	12/31/2999
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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9970	Health club membership, annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9976	Lodging, per diem, not otherwise classified	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

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

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

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

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

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

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

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

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

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of Oklahoma. For other services/members, BCBSOK has contracted with Carelon Medical Benefits Management for utilization management and related services.

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

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