BlueCross BlueShield of Oklahoma

2026 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List
Effective 1/1/2026
(Updated February 2026)

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, 2026.**	**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
0052U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2018	12/31/2999
0054T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
0055T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
0062U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	12/1/2020	12/31/2999
0063U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0071T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	9/1/2020	12/31/2999
0072T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	9/1/2020	12/31/2999
0075T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	1/1/2026	12/31/2999
0076T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0100T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy	1/1/2026	12/31/2999
0101T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	11/1/2016	12/31/2999

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0102T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	9/1/2020	12/31/2999
0105U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	10/15/2025	12/31/2999
0106T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	9/1/2020	12/31/2999
0106U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999

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0107T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	9/1/2020	12/31/2999
0108T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	9/1/2020	12/31/2999
0109T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	9/1/2020	12/31/2999
0110T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	9/1/2020	12/31/2999
0175T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0184T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)	1/1/2011	12/31/2999
0198T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	12/1/2020	12/31/2999
0200T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0201T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0202T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999

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0207T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	9/1/2020	12/31/2999
0208T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold), automated; air only	1/1/2026	12/31/2999
0209T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold), automated; air and bone	1/1/2026	12/31/2999
0210T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold, automated;	1/1/2026	12/31/2999
0211T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold, automated; with speech recognition	1/1/2026	12/31/2999
0212T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	1/1/2026	12/31/2999
0219T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999
0220T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999

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0221T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999
0222T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	12/1/2020	12/31/2999
0224U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	6/1/2023	12/31/2999
0226U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru	6/1/2023	12/31/2999
0232T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	12/1/2020	12/31/2999
0234T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	1/1/2026	12/31/2999

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0235T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	1/1/2026	12/31/2999
0236T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	1/1/2026	12/31/2999
0237T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	1/1/2026	12/31/2999
0238T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	1/1/2026	12/31/2999
0253T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	1/1/2011	12/31/2999

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0263T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/15/2014	12/31/2999
0264T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/15/2014	12/31/2999
0265T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/15/2014	12/31/2999

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0274T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2023	12/31/2999
0278T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	12/1/2020	12/31/2999
0308T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	7/1/2012	12/31/2999

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0312U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2025	12/31/2999
0322U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/15/2024	12/31/2999
0323U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2022	12/31/2999

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0330T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tear film imaging, unilateral or bilateral, with interpretation and report	9/1/2020	12/31/2999
0331T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	9/1/2020	12/31/2999
0332T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	9/1/2020	12/31/2999
0335T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of sinus tarsi implant	12/1/2020	12/31/2999
0337U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0338T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2025	12/31/2999
0339T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2025	12/31/2999
0342T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	9/1/2020	12/31/2999

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0342U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2022	12/31/2999
0345T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	2/15/2016	12/31/2999
0347T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	12/15/2014	12/31/2999
0348T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	12/15/2014	12/31/2999
15999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, excision pressure ulcer	4/16/2015	12/31/2999
0349T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	12/15/2014	12/31/2999

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0350T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	12/15/2014	12/31/2999
0351T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	1/1/2026	12/31/2999
0352T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	1/1/2026	12/31/2999
0353T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast, surgical cavity; real-time intraoperative	1/1/2026	12/31/2999
17999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	1/1/1950	12/31/2999
0354T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	1/1/2026	12/31/2999
0358T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	12/1/2020	12/31/2999

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0378T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999
0379T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999
0397T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	1/1/2016	12/31/2999
0402T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed	11/1/2017	12/31/2999

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0407U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2025	12/31/2999
0408T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
0409T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0410T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	9/1/2020	12/31/2999
0411T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	9/1/2020	12/31/2999
0412T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; pulse generator only	9/1/2020	12/31/2999
0413T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	9/1/2020	12/31/2999
0414T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	9/1/2020	12/31/2999
0415T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0416T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	9/1/2020	12/31/2999
19499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, breast	1/1/1950	12/31/2999
0417T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
0418T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	9/1/2020	12/31/2999
0419T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0420T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas	1/1/2016	12/31/2999
0421U	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
0422T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	1/1/2026	12/31/2999
0436U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (lung), plasma analysis of 388 proteins, using aptamer-based proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy	1/1/2024	12/31/2999
0437T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0439T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0440T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	1/1/2026	12/31/2999
0441T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	1/1/2026	12/31/2999
20999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, musculoskeletal system, general	4/16/2015	12/31/2999
0442T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	1/1/2026	12/31/2999
0443T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0444T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	1/1/2026	12/31/2999
0444U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2024	12/31/2999
0445T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	1/1/2026	12/31/2999
0446U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0447U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2024	12/31/2999
21089	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted maxillofacial prosthetic procedure	1/1/1950	12/31/2999
0449T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	5/1/2021	12/31/2999
0450T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/1/2020	12/31/2999
0464T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Visual evoked potential, testing for glaucoma, with interpretation and report	12/1/2020	12/31/2999
0469T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Retinal polarization scan, ocular screening with on-site automated results, bilateral	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0472T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	1/1/2026	12/31/2999
0473T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	1/1/2026	12/31/2999
0474T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	7/1/2017	12/31/2999
0481T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	9/1/2020	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0490U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2024	12/31/2999
0491U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2024	12/31/2999
0492U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted craniofacial and maxillofacial procedure	1/1/1950	12/31/2999
0494T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
21499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, head	4/16/2015	12/31/2999
0495T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0495U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer	10/1/2024	12/31/2999
0496T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0501U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, neck or thorax	4/16/2015	12/31/2999
0505T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous femoral-popliteal arterial revascularization, 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, with crossing of the occlusive lesion in an extraluminal fashion	1/1/2026	12/31/2999
0506T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	1/1/2026	12/31/2999
0507T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	7/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0509T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electroretinography (ERG) with interpretation and report, pattern (PERG)	5/15/2021	12/31/2999
0510T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of sinus tarsi implant	9/1/2020	12/31/2999
0510U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype	10/1/2024	12/31/2999
0511T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and reinsertion of sinus tarsi implant	12/1/2020	12/31/2999
0511U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	10/1/2024	12/31/2999
0512T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	1/1/2019	12/31/2999
0513T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0514U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	10/1/2024	12/31/2999
0515T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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])	9/1/2020	12/31/2999
0515U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	10/1/2024	12/31/2999
0516T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0517T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
0518T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only	9/1/2020	12/31/2999
0519T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	9/1/2020	12/31/2999
0520T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	9/1/2020	12/31/2999
0521T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0522T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
0524T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0525T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/1/2020	12/31/2999
0526T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0527T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
0528T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	9/1/2020	12/31/2999
0529T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	9/1/2020	12/31/2999
0529U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0530T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0531T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	9/1/2020	12/31/2999
0532T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	9/1/2020	12/31/2999
0532U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999
0533U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0537U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2,500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative	4/1/2025	12/31/2999
0538U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999
0539U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, spine	4/16/2015	12/31/2999
0541T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;	1/1/2026	12/31/2999
0541U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999
22999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, musculoskeletal system	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0542T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report	1/1/2026	12/31/2999
0543T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	1/1/2026	12/31/2999
0543U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999
23929	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, shoulder	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0544T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	10/1/2022	12/31/2999
24999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, humerus or elbow	4/16/2015	12/31/2999
0545T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	1/1/2026	12/31/2999
25999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, forearm or wrist	4/16/2015	12/31/2999
0546T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	1/1/2026	12/31/2999
0547T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	7/1/2019	12/31/2999
26989	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hands or fingers	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0547U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurofilament light chain (NfL), chemiluminescent enzyme immunoassay, plasma, quantitative	4/1/2025	12/31/2999
0552T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	12/15/2020	12/31/2999
0554T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone-mineral density, interpretation and report	1/1/2026	12/31/2999
27299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pelvis or hip joint	4/16/2015	12/31/2999
0555T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
27599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, femur or knee	4/16/2015	12/31/2999
0556T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density	1/1/2026	12/31/2999
0556U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific DNA and RNA by real-time PCR, 12 targets, nasopharyngeal or oropharyngeal swab, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	7/1/2025	12/31/2999
0557T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; interpretation and report	1/1/2026	12/31/2999
0558T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
27899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, leg or ankle	4/16/2015	12/31/2999
0561T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	11/1/2024	12/31/2999
0562T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	11/1/2024	12/31/2999
28899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, foot or toes	4/16/2015	12/31/2999
0563T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	12/1/2020	12/31/2999
0563U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 11 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0564U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 10 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative	7/1/2025	12/31/2999
29799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, casting or strapping	1/1/1950	12/31/2999
0565T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	8/15/2021	12/31/2999
0566T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0568U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurology (dementia), beta amyloid (AB40, AB42, AB42/40 ratio), tau-protein phosphorylated at residue (eg, pTau217), neurofilament light chain (NfL), and glial fibrillary acidic protein (GFAP), by ultra-high sensitivity molecule array detection, plasma, algorithm reported as positive, intermediate, or negative for Alzheimer pathology	7/1/2025	12/31/2999
29999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, arthroscopy	1/1/1950	12/31/2999
0569T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	9/1/2023	12/31/2999
0570T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0571T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2025	12/31/2999
30999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nose	1/1/1950	12/31/2999
0572T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of substernal implantable defibrillator electrode	2/15/2025	12/31/2999
0572U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (prostate), high-throughput telomere length quantification by FISH, whole blood, diagnostic algorithm reported as risk of prostate cancer	7/1/2025	12/31/2999
0573T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of substernal implantable defibrillator electrode	2/15/2025	12/31/2999
0574T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, accessory sinuses	1/1/1950	12/31/2999
0575T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2025	12/31/2999
0575U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation medicine (liver allograft rejection), miRNA gene expression profiling by RT-PCR of 4 genes (miR-122, miR-885, miR-23a housekeeping, spike-in control), serum, algorithm reported as risk of liver allograft rejection	10/1/2025	12/31/2999
31599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, larynx	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0576T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2025	12/31/2999
0576U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation medicine (liver allograft rejection), quantitative donor-derived cell-free DNA (cfDNA) by whole genome next-generation sequencing, plasma and mRNA gene expression profiling by multiplex real-time PCR of 56 genes, whole blood, combined algorithm reported as a rejection risk score	10/1/2025	12/31/2999
0577T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0578T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2025	12/31/2999
0578U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (cutaneous melanoma), RNA, gene expression profiling by real-time qPCR of 10 genes (8 content and 2 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reports a binary result, either low-risk or high-risk for sentinel lymph node metastasis and recurrence	10/1/2025	12/31/2999
0579T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2025	12/31/2999
0580T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of substernal implantable defibrillator pulse generator only	2/15/2025	12/31/2999
0582T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0582U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rare diseases (constitutional disease/hereditary disorders), rapid whole genome DNA sequencing for single-nucleotide variants, insertions/deletions, copy number variations, blood, saliva, tissue sample, variants reported	10/1/2025	12/31/2999
0583U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rare diseases (constitutional disease/hereditary disorders), rapid whole genome comparator DNA sequencing for single-nucleotide variants, insertions/deletions, copy number variations, blood, saliva, tissue sample, variants reported with proband results (List separately in addition to code for primary procedure)	10/1/2025	12/31/2999
0584T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous	1/15/2026	12/31/2999
31899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, trachea, bronchi	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0585T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic	1/15/2026	12/31/2999
0585U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Targeted genomic sequence analysis panel, solid organ neoplasm, circulating cell-free DNA (cfDNA) analysis from plasma of 521 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, and microsatellite instability, report shows identified mutations, including variants with clinical actionability	10/1/2025	12/31/2999
0586T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open	1/15/2026	12/31/2999
0586U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology, mRNA, gene expression profiling of 216 genes (204 targeted and 12 housekeeping genes), RNA expression analysis, formalin-fixed paraffin-embedded (FFPE) tissue, quantitative, reported as log2 ratio per gene	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0587T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/1/2021	12/31/2999
32999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lungs and pleura	1/1/1950	12/31/2999
0588T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0589T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0590T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/1/2021	12/31/2999
0591T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; individual, initial assessment	1/1/2026	12/31/2999
0592T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	1/1/2026	12/31/2999
0593T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0594T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	1/1/2026	12/31/2999
0596T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	11/15/2023	12/31/2999
0597T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	11/15/2023	12/31/2999
0598T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time fluorescence wound imaging with, clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; first anatomic site (eg, lower extremity, right leg)	10/1/2024	12/31/2999
0598U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastroenterology (irritable bowel syndrome), IgG antibodies to 18 food items by microarray-based immunoassay, whole blood or serum, report as elevated (positive) or normal (negative) antibody levels	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0599T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time fluorescence wound imaging with, clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; each additional anatomic site (eg, upper extremity, left leg) (List separately in addition to code for primary procedure)	10/1/2024	12/31/2999
0600T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous	9/1/2023	12/31/2999
0601T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	9/1/2023	12/31/2999
0601U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (periprosthetic joint infection), analysis of 11 biomarkers (alpha defensins 1-3, Creactive protein, microbial antigens for Staphylococcus [SPA, SPB], Enterococcus, Candida, and C. acnes, total nucleated cell count, percent neutrophils, RBC count, and absorbance at 280 nm) using immunoassays, hematology, clinical chemistry, synovial fluid, and diagnostic algorithm reported as a probability score	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0602T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	4/1/2021	12/31/2999
0602U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endocrinology (diabetes), insulin (INS) gene methylation using digital droplet PCR, insulin, and C peptide immunoassay, serum, Hemoglobin A1c immunoassay, whole blood, algorithm reported as diabetes-risk score	1/1/2026	12/31/2999
0603T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	4/1/2021	12/31/2999
0603U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Drug assay, presumptive, 77 drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS), results reported as positive or negative	1/1/2026	12/31/2999
0604T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0605T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	1/1/2026	12/31/2999
0606T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	1/1/2026	12/31/2999
0607T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0607U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	1/1/2026	12/31/2999
0608T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	1/1/2026	12/31/2999
0608U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0609T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	1/1/2026	12/31/2999
0610T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	1/1/2026	12/31/2999
0611T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	1/1/2026	12/31/2999
0611U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	1/1/2026	12/31/2999
0612T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0612U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	1/1/2026	12/31/2999
0613T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed	1/1/2026	12/31/2999
0613U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (urothelial carcinoma), DNA methylation and mutation analysis of 6 biomarkers (TWIST1, OTX1, ONECUT2, FGFR3, HRAS, TERT promoter region), methylation-specific PCR and targeted next-generation sequencing, urine, algorithm reported as a probability index for bladder cancer and upper tract urothelial carcinoma	1/1/2026	12/31/2999
0614T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of substernal implantable defibrillator pulse generator	2/15/2025	12/31/2999
0615T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0620T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2021	12/31/2999
0621T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser;	1/1/2021	12/31/2999
33999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, cardiac surgery	1/1/1950	12/31/2999
0622T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	1/1/2021	12/31/2999
36299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular injection	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0627T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	1/1/2021	12/31/2999
0628T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2021	12/31/2999
0629T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	1/1/2021	12/31/2999
0630T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0632T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	1/1/2026	12/31/2999
0639T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	1/1/2021	12/31/2999
0640T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2021	12/31/2999
0643T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0644T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed	1/1/2026	12/31/2999
0645T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0646T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2021	12/31/2999
0647T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0650T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2021	12/31/2999
0651T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	1/1/2023	12/31/2999
0652T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	1/1/2026	12/31/2999
0653T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	1/1/2026	12/31/2999
0654T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter	1/1/2026	12/31/2999
0656T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	7/1/2021	12/31/2999
0657T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0658T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	1/1/2026	12/31/2999
0659T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0664T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open, from cadaver donor	8/15/2021	12/31/2999
0665T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open, from living donor	8/15/2021	12/31/2999
0666T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	8/15/2021	12/31/2999
0667T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0668T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/15/2021	12/31/2999
0669T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	8/15/2021	12/31/2999
0670T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	8/15/2021	12/31/2999
0672T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	1/1/2023	12/31/2999
0673T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	1/1/2026	12/31/2999
0674T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0675T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead	1/1/2026	12/31/2999
0676T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0677T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0678T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0679T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0680T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)	1/1/2026	12/31/2999
0681T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0682T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0683T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0684T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0685T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0686T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	1/1/2026	12/31/2999
0687T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	1/1/2026	12/31/2999
0688T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0689T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure)	1/1/2026	12/31/2999
0690T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0691T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report	1/1/2026	12/31/2999
0692T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic ultrafiltration	5/1/2024	12/31/2999
0693T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0694T	EIU: Procedure/service not 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-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	1/1/2026	12/31/2999
0695T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement	1/1/2026	12/31/2999
0696T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up interrogation or programming device evaluation	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0697T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	1/1/2026	12/31/2999
0698T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0699T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection, posterior chamber of eye, medication	1/1/2026	12/31/2999
0700T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; first lesion	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0701T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0704T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0705T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	1/1/2026	12/31/2999
0706T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	1/1/2026	12/31/2999
0708T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intradermal cancer immunotherapy; preparation and initial injection	1/1/2026	12/31/2999
0709T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0714T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume less than 50 mL	1/1/2026	12/31/2999
0716T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	1/1/2026	12/31/2999
0717T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0718T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	1/1/2026	12/31/2999
0719T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0721T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999
37501	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vascular endoscopy procedure	1/1/1950	12/31/2999
0722T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0723T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0724T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0725T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular device implantation, unilateral	1/1/2026	12/31/2999
0726T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of implanted vestibular device, unilateral	1/1/2026	12/31/2999
0727T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and replacement of implanted vestibular device, unilateral	1/1/2026	12/31/2999
0728T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Diagnostic analysis of vestibular implant, unilateral; with initial programming	1/1/2026	12/31/2999
0729T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming	1/1/2026	12/31/2999
0730T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0731T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative AI-based facial phenotype analysis with report	1/1/2026	12/31/2999
0732T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Immunotherapy administration with electroporation, intramuscular	1/1/2026	12/31/2999
37799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular surgery	1/1/1950	12/31/2999
0733T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
38129	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spleen	1/1/1950	12/31/2999
0734T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0735T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0736T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	1/1/2026	12/31/2999
0737T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xenograft implantation into the articular surface	7/1/2022	12/31/2999
0737T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xenograft implantation into the articular surface	1/1/2026	12/31/2999
0738T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0739T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	1/1/2026	12/31/2999
0740T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	9/1/2023	12/31/2999
0741T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	9/1/2023	12/31/2999
0742T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0743T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2023	12/31/2999
0744T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999
0745T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0746T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	1/1/2026	12/31/2999
0747T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	1/1/2026	12/31/2999
0748T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	9/1/2023	12/31/2999
38589	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, lymphatic system	1/1/1950	12/31/2999
0749T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hemic or lymphatic system	1/1/1950	12/31/2999
0750T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	1/1/2026	12/31/2999
39499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, mediastinum	1/1/1950	12/31/2999
0751T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
39599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, diaphragm	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0752T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
40799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lips	1/1/1950	12/31/2999
0753T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
40899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vestibule of mouth	1/1/1950	12/31/2999
0754T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0755T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0756T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0757T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
41599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, tongue, floor of mouth	1/1/1950	12/31/2999
0758T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0759T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
41899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, dentoalveolar structures	1/1/1950	12/31/2999
0760T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0761T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0762T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
42299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, palate, uvula	1/1/1950	12/31/2999
0763T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
42699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, salivary glands or ducts	1/1/1950	12/31/2999
0764T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0765T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	1/1/2026	12/31/2999
42999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pharynx, adenoids, or tonsils	1/1/1950	12/31/2999
0766T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2023	12/31/2999
0767T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0770T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999
0771T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0772T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	9/1/2023	12/31/2999
0773T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0774T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	9/1/2023	12/31/2999
43289	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, esophagus	1/1/1950	12/31/2999
0776T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999
0777T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0778T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999
0779T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	9/1/2023	12/31/2999
0780T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract	1/1/2023	12/31/2999
0781T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999
0782T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0783T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	1/1/2023	12/31/2999
0784T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	1/1/2024	12/31/2999
0785T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	1/1/2024	12/31/2999
43499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, esophagus	1/1/1950	12/31/2999
0786T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	1/1/2024	12/31/2999
0787T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0788T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999
0789T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0790T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	5/15/2024	12/31/2999
0791T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	7/1/2023	12/31/2999
0792T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional	7/1/2023	12/31/2999
43659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, stomach	1/1/1950	12/31/2999
0793T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0794T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0795T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0796T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999
0797T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0798T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999
0799T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2023	12/31/2999
0800T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0801T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999
0802T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0803T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2023	12/31/2999
0804T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2023	12/31/2999
0805T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0806T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	1/1/2026	12/31/2999
0807T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2023	12/31/2999
0808T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2023	12/31/2999
0810T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, stomach	1/1/1950	12/31/2999
0811T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	1/1/2024	12/31/2999
44238	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, intestine (except rectum)	1/1/1950	12/31/2999
44799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, small intestine	1/1/1950	12/31/2999
0812T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	1/1/2024	12/31/2999
44899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, Meckel's diverticulum and the mesentery	1/1/1950	12/31/2999
44979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, appendix	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0813T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	7/1/2024	12/31/2999
45399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, colon	1/1/2015	12/31/2999
0814T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	1/1/2026	12/31/2999
45499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, rectum	1/1/2006	12/31/2999
0815T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine	1/1/2026	12/31/2999
45999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, rectum	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0816T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	7/1/2024	12/31/2999
0817T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999
0818T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	7/1/2024	12/31/2999
46999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anus	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0819T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial	1/1/2026	12/31/2999
0820T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999
0820T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
47379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopic procedure, liver	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0821T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0822T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0823T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2024	12/31/2999
47399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, liver	1/1/1950	12/31/2999
0824T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2024	12/31/2999
47579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, biliary tract	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0825T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2024	12/31/2999
47999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, biliary tract	1/1/1950	12/31/2999
0826T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2024	12/31/2999
0827T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
48999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pancreas	1/1/1950	12/31/2999
0828T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49329	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
0829T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0830T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
0831T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0832T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0833T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0834T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0835T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
50549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, renal	1/1/1950	12/31/2999
0837T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0838T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0839T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
50949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, ureter	1/1/1950	12/31/2999
0840T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0841T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
51999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, bladder	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0842T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0843T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), initial site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0844T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), each additional site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0845T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0846T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0847T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0848T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0849T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0850T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0851T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0852T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
53899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, urinary system	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0853T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0854T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0855T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for bone marrow, smear interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0856T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for electron microscopy, diagnostic (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0857T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0858T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	10/1/2024	12/31/2999
0859T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0860T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities	1/1/2026	12/31/2999
0861T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0862T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	1/1/2024	12/31/2999
0863T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	1/1/2024	12/31/2999
0864T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	7/1/2024	12/31/2999
0865T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
54699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, testis	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0866T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
55559	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spermatic cord	1/1/1950	12/31/2999
0867T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL	1/1/2026	12/31/2999
0868T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, with interpretation and report	6/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0869T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed	1/1/2026	12/31/2999
0870T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2025	12/31/2999
0871T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	5/15/2025	12/31/2999
55899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, male genital system	1/1/1950	12/31/2999
0872T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0873T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2025	12/31/2999
0874T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	5/15/2025	12/31/2999
0875T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	5/15/2025	12/31/2999
0876T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula)	1/1/2026	12/31/2999
0877T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0878T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure	1/1/2026	12/31/2999
0879T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission	1/1/2026	12/31/2999
0880T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
0881T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cryotherapy of the oral cavity using temperature regulated fluid cooling system, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0882T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0883T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0884T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
58578	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, uterus	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0885T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
58579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hysteroscopy procedure, uterus	1/1/1950	12/31/2999
0886T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
0887T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
58679	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, oviduct, ovary	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0888T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance	1/1/2026	12/31/2999
0893T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
58999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, female genital system (nonobstetrical)	1/1/1950	12/31/2999
0897T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	1/1/2026	12/31/2999
0898T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0899T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0900T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
59897	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	1/1/1950	12/31/2999
0901T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of bone marrow sampling port, including imaging guidance when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
59898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, maternity care and delivery	1/1/1950	12/31/2999
0902T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	1/1/2026	12/31/2999
59899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, maternity care and delivery	1/1/1950	12/31/2999
0903T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	1/1/2026	12/31/2999
60659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, endocrine system	1/1/1950	12/31/2999
0904T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	1/1/2026	12/31/2999
0905T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only	1/1/2026	12/31/2999
60699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, endocrine system	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0906T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0907T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	1/1/2026	12/31/2999
0908T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	1/1/2026	12/31/2999
0909T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	1/1/2026	12/31/2999
0910T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of integrated neurostimulation system, vagus nerve	1/1/2026	12/31/2999
0911T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0912T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by physician or other qualified health care professional	1/1/2026	12/31/2999
0913T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0914T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch (List separately in addition to code for percutaneous coronary stent or atherectomy intervention)	1/1/2026	12/31/2999
0915T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0921T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead only	1/1/2025	12/31/2999
0922T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only	1/1/2025	12/31/2999
0923T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of permanent cardiac contractility modulation defibrillation pulse generator only	1/1/2025	12/31/2999
0924T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters	1/1/2025	12/31/2999
0925T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0926T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0927T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system	1/1/2025	12/31/2999
0928T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0929T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0930T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0931T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0932T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0933T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0934T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0935T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0936T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation therapy of retina, single session	1/1/2026	12/31/2999
0937T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999
0938T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)	1/1/2026	12/31/2999
0939T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report	1/1/2026	12/31/2999
0940T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0941T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization	1/1/2026	12/31/2999
0942T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with removal and replacement of prostatic urethral scaffold	1/1/2026	12/31/2999
0943T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with removal of prostatic urethral scaffold	1/1/2026	12/31/2999
0944T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	1/1/2026	12/31/2999
0945T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative assessment for abnormal (tumor) tissue, in-vivo, following partial mastectomy (eg, lumpectomy) using computer-aided fluorescence imaging	1/1/2026	12/31/2999
0946T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure, including data acquisition, data preparation and transmission, interpretation and report (including CT scan of the joint or extremity performed with paired views)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0947T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
0948T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review, and report(s) by a physician or other qualified health care professional	7/1/2025	12/31/2999
0949T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	7/1/2025	12/31/2999
0950T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of benign prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	7/1/2025	12/31/2999
0951T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; initial placement, including mastoidectomy, placement of and attachment to sound processor	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0952T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement, with mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0953T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement, without mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0954T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; replacement of sound processor only, with attachment to existing transducers	1/1/2026	12/31/2999
0955T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; removal, including removal of sound processor and all implant components	1/1/2026	12/31/2999
0956T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Partial craniectomy, channel creation, and tunneling of electrode for sub-scalp implantation of an electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0957T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision of sub-scalp implanted electrode array, receiver, and telemetry unit for electrode, when required, including imaging guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nervous system	1/1/1950	12/31/2999
0958T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of sub-scalp implanted electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0959T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0960T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of sub-scalp implanted electrode array, receiver, and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0961T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (List separately in addition to code for primary procedure)	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0961T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0962T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg, reduced ejection fraction, cardiac murmurs, atrial fibrillation), with review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0963T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anoscopy with directed submucosal injection of bulking agent into anal canal	7/1/2025	12/31/2999
0964T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0965T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism	7/1/2025	12/31/2999
0966T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism	7/1/2025	12/31/2999
0967T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system	7/1/2025	12/31/2999
0967T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0968T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of epicranial neurostimulator system, including electrode array and pulse generator, with connection to electrode array	1/1/2026	12/31/2999
0969T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of epicranial neurostimulator system	1/1/2026	12/31/2999
0970T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor	7/1/2025	12/31/2999
0970T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor	1/1/2026	12/31/2999
0971T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, malignant breast tumor(s), percutaneous, laser, including imaging guidance when performed, unilateral	1/1/2026	12/31/2999
0972T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0973T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; first 100 sq cm	1/1/2026	12/31/2999
0974T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
66999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anterior segment of eye	1/1/1950	12/31/2999
0975T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; first 100 sq cm	1/1/2026	12/31/2999
67299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, posterior segment	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0976T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
67399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, extraocular muscle	1/1/1950	12/31/2999
0977T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Upper gastrointestinal blood detection, sensor capsule, with interpretation and report	1/1/2026	12/31/2999
0978T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil	7/1/2025	12/31/2999
0979T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; soft palate only	7/1/2025	12/31/2999
0980T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; base of tongue and lingual tonsil only	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0981T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed	7/1/2025	12/31/2999
0981T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed	1/1/2026	12/31/2999
0982T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment	7/1/2025	12/31/2999
67599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, orbit	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0982T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0983T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	7/1/2025	12/31/2999
0983T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0984T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	7/1/2025	12/31/2999
0984T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0985T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0985T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0986T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	7/1/2025	12/31/2999
0986T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0987T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	7/1/2025	12/31/2999
0987T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0988T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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 and subfascial	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0989T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous and subfascial	1/1/2026	12/31/2999
0990T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcervical instillation of biodegradable hydrogel materials, intrauterine	1/1/2026	12/31/2999
67999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, eyelids	1/1/1950	12/31/2999
0991T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, with low-energy lithotripsy and acoustically actuated microspheres, including imaging	1/1/2026	12/31/2999
68399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, conjunctiva	1/1/1950	12/31/2999
0992T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
68899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lacrimal system	1/1/1950	12/31/2999
0993T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat with concurrent computed tomography scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0994T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; percutaneous	1/1/2026	12/31/2999
0995T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; open	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, external ear	1/1/1950	12/31/2999
0996T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed	1/1/2026	12/31/2999
0997T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location, dose, and intensity for magnetic stimulation therapy, derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram, including automated data processing, transmission, analysis, generation of treatment parameters with review, interpretation, and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0998T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus, utilizing magnetic resonance imaging-based neuronavigation, with management, per day	1/1/2026	12/31/2999
0999T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed	1/1/2026	12/31/2999
69799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, middle ear	1/1/1950	12/31/2999
1000T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, administration of muscle progenitor cells into the urethral sphincter, including cystoscopy and post-void residual ultrasound, when performed	1/1/2026	12/31/2999
69949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, inner ear	1/1/1950	12/31/2999
1001T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, temporal bone, middle fossa approach	1/1/1950	12/31/2999
1002T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Air displacement plethysmography, whole body composition assessment, with interpretation and report	1/1/2026	12/31/2999
1003T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (eg, first carpometacarpal total joint)	1/1/2026	12/31/2999
1004T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; without programming	1/1/2026	12/31/2999
76496	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1005T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, first 15 minutes face-to-face time with physician or other qualified health care professional	1/1/2026	12/31/2999
76497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted computed tomography procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
1006T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
76498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1007T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electroencephalogram from implanted sub-scalp continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording, without video	1/1/2026	12/31/2999
76499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic radiographic procedure	4/16/2015	12/31/2999
1008T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of sub-scalp implanted continuous bilateral electroencephalography monitoring system, device fitting, initial set-up, and patient education in wearing of system and use of equipment	1/1/2026	12/31/2999
1009T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of a sub-scalp implanted continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording without video	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
76999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ultrasound procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
1010T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computerized ophthalmic analysis of monocular eye movements using retinal-based eye-tracking without spatial calibration, including fixation, microsaccades, drift, and horizontal saccades, when performed, unilateral or bilateral, with interpretation and report	1/1/2026	12/31/2999
77299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology clinical treatment planning	1/1/1950	12/31/2999
1011T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation (PBM) therapy of oral cavity, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	1/1/2026	12/31/2999
77399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	4/16/2015	12/31/2999
1012T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motorized ab interno trephination of sclera (sclerostomy), or trabecular meshwork (trabeculostomy), 1 or more, including injection of antifibrotic agents, when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
77499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology treatment management	1/1/1950	12/31/2999
1013T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopy, surgical, implantation or replacement of lower esophageal sphincter neurostimulator electrode array and neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver, including cruroplasty and/or electronic analysis, when performed	1/1/2026	12/31/2999
77799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, clinical brachytherapy	1/1/1950	12/31/2999
1014T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic revision or removal, lower esophageal sphincter neurostimulator electrodes	1/1/2026	12/31/2999
78099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted endocrine procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1015T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal, lower esophageal sphincter neurostimulator pulse generator or receiver	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1016T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; intraoperative, with programming	1/1/2026	12/31/2999
78299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999
1017T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, without reprogramming	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1018T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, with reprogramming	1/1/2026	12/31/2999
78499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1020T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Raman spectroscopy of 1 or more skin lesions, with probability score for malignant risk derived by algorithmic analysis of data from each lesion	1/1/2026	12/31/2999
78599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted respiratory procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1021T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Active thoracic irrigation (separate procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted nervous system procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1022T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; intra-abdominal/pelvic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
78799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted genitourinary procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1023T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
78999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999
1024T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; soft tissue (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
79999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiopharmaceutical therapy, unlisted procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1025T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification	1/1/2026	12/31/2999
80299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Quantitation of therapeutic drug, not elsewhere specified	1/1/1950	12/31/2999
9701A	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	NON-PRESCRIPTION DRUGS	1/1/1950	12/31/2999
81099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted urinalysis procedure	1/1/1950	12/31/2999
11200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	9/24/2012	12/31/2999
11201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/24/2012	12/31/2999
11920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
11921	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	4/1/2009	12/31/2999
11922	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2009	12/31/2999
81479	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted molecular pathology procedure	1/1/2013	12/31/2999
11950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	4/1/2009	12/31/2999
81599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted multianalyte assay with algorithmic analysis	1/1/2013	12/31/2999
11951	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	4/1/2009	12/31/2999
11952	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	4/1/2009	12/31/2999
11954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
11960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of tissue expander(s) for other than breast, including subsequent expansion	4/1/2009	12/31/2999
11980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	1/1/2005	12/31/2999
11981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)	1/1/2005	12/31/2999
11982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, non-biodegradable drug delivery implant	1/1/2005	12/31/2999
11983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal with reinsertion, non-biodegradable drug delivery implant	1/1/2005	12/31/2999
15011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	1/1/2025	12/31/2999
15012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
15013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
84999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemistry procedure	6/20/2014	12/31/2999
15014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
85999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematology and coagulation procedure	1/1/1950	12/31/2999
15015	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
15016	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15017	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
15018	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
15271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2023	12/31/2999
15272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2023	12/31/2999
15274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2023	12/31/2999
86486	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Skin test; unlisted antigen, each	4/16/2015	12/31/2999
15275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2023	12/31/2999
86849	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immunology procedure	1/1/1950	12/31/2999
15277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2023	12/31/2999
15758	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Free fascial flap with microvascular anastomosis	11/15/2010	12/31/2999
86999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted transfusion medicine procedure	4/16/2015	12/31/2999
87797	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	10/24/2019	12/31/2999
15771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	1/15/2021	12/31/2999
87798	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/15/2021	12/31/2999
87799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism	10/24/2019	12/31/2999
15775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; 1 to 15 punch grafts	9/24/2012	12/31/2999
87899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	10/24/2019	12/31/2999
15776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; more than 15 punch grafts	9/24/2012	12/31/2999
87999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted microbiology procedure	4/16/2015	12/31/2999
15780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	4/1/2009	12/31/2999
15781	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; segmental, face	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; regional, other than face	4/1/2009	12/31/2999
15783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; superficial, any site (eg, tattoo removal)	4/1/2009	12/31/2999
15786	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Abrasion; single lesion (eg, keratosis, scar)	4/1/2009	12/31/2999
15787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	4/1/2009	12/31/2999
15788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, facial; epidermal	4/1/2009	12/31/2999
15789	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, facial; dermal	4/1/2009	12/31/2999
15792	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, nonfacial; epidermal	4/1/2009	12/31/2999
15793	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, nonfacial; dermal	4/1/2009	12/31/2999
15820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, lower eyelid;	9/24/2012	12/31/2999
15821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, lower eyelid; with extensive herniated fat pad	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, upper eyelid;	4/1/2009	12/31/2999
15823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	4/1/2009	12/31/2999
15825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	9/24/2012	12/31/2999
15828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; cheek, chin, and neck	9/24/2012	12/31/2999
88099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted necropsy (autopsy) procedure	4/16/2015	12/31/2999
15829	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	9/24/2012	12/31/2999
15830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	4/1/2009	12/31/2999
88199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytopathology procedure	4/16/2015	12/31/2999
15832	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytogenetic study	10/24/2014	12/31/2999
15833	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	9/24/2012	12/31/2999
15834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	9/24/2012	12/31/2999
88399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted surgical pathology procedure	4/16/2015	12/31/2999
15835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	9/24/2012	12/31/2999
88749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted in vivo (eg, transcutaneous) laboratory service	1/1/2011	12/31/2999
15836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	9/24/2012	12/31/2999
89240	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous pathology test	1/1/1950	12/31/2999
15837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	9/24/2012	12/31/2999
15839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	9/24/2012	12/31/2999
15847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2009	12/31/2999
15876	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; head and neck	9/24/2012	12/31/2999
15877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; trunk	9/24/2012	12/31/2999
15878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; upper extremity	9/24/2012	12/31/2999
15879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; lower extremity	9/24/2012	12/31/2999
17106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	1/1/2005	12/31/2999
17107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
17108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	1/1/2005	12/31/2999
17380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrolysis epilation, each 30 minutes	9/24/2012	12/31/2999
89398	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted reproductive medicine laboratory procedure	1/1/2010	12/31/2999
90399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immune globulin	1/1/1950	12/31/2999
19105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	9/24/2012	12/31/2999
19300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy for gynecomastia	9/1/2020	12/31/2999
19303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy, simple, complete	1/1/2007	12/31/2999
19325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Breast augmentation with implant	4/1/2009	12/31/2999
90749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vaccine/toxoid	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intact breast implant	4/1/2009	12/31/2999
19330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	4/1/2009	12/31/2999
19340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of breast implant on same day of mastectomy (ie, immediate)	4/1/2009	12/31/2999
19342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of breast implant on separate day from mastectomy	4/1/2009	12/31/2999
19350	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nipple/areola reconstruction	6/1/2017	12/31/2999
19355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Correction of inverted nipples	4/1/2009	12/31/2999
90899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted psychiatric service or procedure	1/1/1950	12/31/2999
19357	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	6/1/2017	12/31/2999
90999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted dialysis procedure, inpatient or outpatient	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	4/1/2009	12/31/2999
19371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	4/1/2009	12/31/2999
19499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, breast	11/1/2017	12/31/2999
20527	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	1/1/2012	12/31/2999
20560	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	12/1/2020	12/31/2999
20561	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Needle insertion(s) without injection(s); 3 or more muscles	12/1/2020	12/31/2999
20979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	1/1/1950	12/31/2999
91299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic gastroenterology procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
20982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	8/15/2007	12/31/2999
20983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	6/1/2023	12/31/2999
20985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
92499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ophthalmological service or procedure	1/1/1950	12/31/2999
21073	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	1/15/2013	12/31/2999
21083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation; palatal lift prosthesis	11/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; augmentation (autograft, allograft, prosthetic material)	9/24/2012	12/31/2999
21121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomy, single piece	9/24/2012	12/31/2999
21122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	9/24/2012	12/31/2999
21123	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	9/24/2012	12/31/2999
21244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	4/1/2009	12/31/2999
21245	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, subperiosteal implant; partial	4/1/2009	12/31/2999
92700	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted otorhinolaryngological service or procedure	1/1/1950	12/31/2999
21246	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, subperiosteal implant; complete	4/1/2009	12/31/2999
21247	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	5/15/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21248	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	5/15/2009	12/31/2999
21249	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	5/15/2009	12/31/2999
21685	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hyoid myotomy and suspension	11/1/2007	12/31/2999
22505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation of spine requiring anesthesia, any region	9/1/2020	12/31/2999
22526	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	1/1/2023	12/31/2999
22527	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
22586	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22836	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	5/15/2024	12/31/2999
22837	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	5/15/2024	12/31/2999
22838	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	5/15/2024	12/31/2999
93799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular service or procedure	1/1/1950	12/31/2999
22867	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	1/1/2023	12/31/2999
93998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted noninvasive vascular diagnostic study	1/1/2012	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted pulmonary service or procedure	1/1/1950	12/31/2999
95199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted allergy/clinical immunologic service or procedure	1/1/1950	12/31/2999
27278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis, sacroiliac joint, percutaneous, or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral placement of intra-articular device(s), without cortical piercing	5/15/2024	12/31/2999
27299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, pelvis or hip joint	6/1/2017	12/31/2999
27702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, ankle; with implant (total ankle)	12/15/2009	12/31/2999
27703	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, ankle; revision, total ankle	5/1/2015	12/31/2999
27704	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ankle implant	5/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
28890	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2020	12/31/2999
95999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted neurological or neuromuscular diagnostic procedure	1/1/1950	12/31/2999
29999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, arthroscopy	11/1/2017	12/31/2999
30140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucous resection inferior turbinate, partial or complete, any method	10/1/2025	12/31/2999
30468	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	5/15/2021	12/31/2999
30469	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	1/1/2023	12/31/2999
96379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	1/1/2009	12/31/2999
31242	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31243	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	5/15/2024	12/31/2999
31295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	6/5/2018	12/31/2999
31298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	1/1/2018	12/31/2999
96549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemotherapy procedure	1/1/1950	12/31/2999
31573	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	1/1/2017	12/31/2999
31574	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	1/1/2017	12/31/2999
96999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special dermatological service or procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31649	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	12/1/2020	12/31/2999
97039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted modality (specify type and time if constant attendance)	1/1/1950	12/31/2999
31660	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	5/15/2025	12/31/2999
97139	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic procedure (specify)	1/1/1950	12/31/2999
31661	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	5/15/2025	12/31/2999
32553	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	10/3/2016	12/31/2999
32664	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thoracoscopy, surgical; with thoracic sympathectomy	8/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
32994	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2018	12/31/2999
32998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	6/1/2007	12/31/2999
97799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted physical medicine/rehabilitation service or procedure	1/1/1950	12/31/2999
33211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	2/1/2009	12/31/2999
33213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacemaker pulse generator only; with existing dual leads	2/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	2/1/2009	12/31/2999
33267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	10/1/2022	12/31/2999
33268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	10/1/2022	12/31/2999
33269	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2015	12/31/2999
33271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of subcutaneous implantable defibrillator electrode	1/1/2015	12/31/2999
33274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
33275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	5/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2024	12/31/2999
33277	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	5/15/2024	12/31/2999
33278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	5/15/2024	12/31/2999
99050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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	1/1/1950	12/31/2999
33279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99056	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	1/1/1950	12/31/2999
33280	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	5/15/2024	12/31/2999
99058	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	1/1/1950	12/31/2999
33281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repositioning of phrenic nerve stimulator transvenous lead(s)	5/15/2024	12/31/2999
99070	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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)	1/1/1950	12/31/2999
33285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion, subcutaneous cardiac rhythm monitor, including programming	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	5/15/2024	12/31/2999
99075	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Medical testimony	1/1/1950	12/31/2999
33288	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	5/15/2024	12/31/2999
33289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2017	12/31/2999
99078	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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)	1/1/1950	12/31/2999
33361	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	1/1/2013	12/31/2999
99080	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	1/1/1950	12/31/2999
33362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33363	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	11/1/2015	12/31/2999
99082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unusual travel (eg, transportation and escort of patient)	1/1/1950	12/31/2999
33364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	11/1/2015	12/31/2999
33365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	11/1/2015	12/31/2999
33366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	1/1/2014	12/31/2999
99199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special service, procedure or report	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2013	12/31/2999
33368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2013	12/31/2999
99429	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted preventive medicine service	1/1/1950	12/31/2999
33369	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	2/15/2025	12/31/2999
33418	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	2/15/2016	12/31/2999
33419	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	2/15/2016	12/31/2999
33477	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	1/1/2016	12/31/2999
33548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)	1/15/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stent graft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation	1/1/2026	12/31/2999
33883	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Delayed placement of proximal extension prosthesis(es) not involving coverage of the left subclavian artery origin, after endovascular repair of the thoracic aorta, including pre-procedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted evaluation and management service	1/1/1950	12/31/2999
33927	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	1/1/2018	12/31/2999
33928	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of total replacement heart system (artificial heart)	1/1/2018	12/31/2999
33929	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	1/1/2018	12/31/2999
33945	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heart transplant, with or without recipient cardiectomy	12/29/2025	12/31/2999
33975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device; extracorporeal, single ventricle	7/27/2009	12/31/2999
33976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device; extracorporeal, biventricular	7/27/2009	12/31/2999
33979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	7/27/2009	12/31/2999
33981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	1/1/2010	12/31/2999
33983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	1/1/2010	12/31/2999
33990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	1/1/2013	12/31/2999
33991	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	1/1/2013	12/31/2999
33992	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	1/1/2013	12/31/2999
33993	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99600	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted home visit service or procedure	1/1/1950	12/31/2999
33999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, cardiac surgery	11/1/2017	12/31/2999
35602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bypass graft, with other than vein; carotid-contralateral carotid	1/1/2026	12/31/2999
36260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)	3/1/2007	12/31/2999
36465	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2018	12/31/2999
36466	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	9/24/2012	12/31/2999
36470	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; single incompetent vein (other than telangiectasia)	4/1/2009	12/31/2999
36471	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	4/1/2009	12/31/2999
36473	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	12/1/2020	12/31/2999
36474	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	12/1/2020	12/31/2999
36475	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	1/1/2005	12/31/2999
0101T	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	7/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36476	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	1/1/2005	12/31/2999
36478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	1/1/2005	12/31/2999
36479	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	1/1/2005	12/31/2999
36482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/1/2019	12/31/2999
36511	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis; for white blood cells	1/1/2003	12/31/2999
36522	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photopheresis, extracorporeal	7/27/2009	12/31/2999
36563	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	3/1/2007	12/31/2999
37215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/24/2012	12/31/2999
37217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2014	12/31/2999
37218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2014	12/31/2999
37242	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2014	12/31/2999
37244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2014	12/31/2999
37254	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37255	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37256	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37258	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37259	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37262	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999
37264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37265	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999
37266	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37269	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37279	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999
37281	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999
37283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37288	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999
37297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999
37299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	1/1/1950	12/31/2999
37718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and stripping, short saphenous vein	1/1/2006	12/31/2999
37722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	1/1/2006	12/31/2999
37735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
37760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	1/1/1950	12/31/2999
37761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	1/1/2010	12/31/2999
37765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	1/1/2004	12/31/2999
37766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	1/1/2004	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	1/1/1950	12/31/2999
37785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	1/1/1950	12/31/2999
37788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile revascularization, artery, with or without vein graft	2/15/2007	12/31/2999
37790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile venous occlusive procedure	2/15/2007	12/31/2999
38204	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	7/27/2009	12/31/2999
38205	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	7/27/2009	12/31/2999
38207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	7/27/2009	12/31/2999
38208	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	7/27/2009	12/31/2999
38209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	7/27/2009	12/31/2999
38211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	7/27/2009	12/31/2999
38212	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	7/27/2009	12/31/2999
38213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; platelet depletion	7/27/2009	12/31/2999
38214	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	7/27/2009	12/31/2999
38215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	7/27/2009	12/31/2999
38225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
38226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38227	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	1/1/2025	12/31/2999
38228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cells for administration, autologous	1/1/2025	12/31/2999
38232	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bone marrow harvesting for transplantation; autologous	1/1/2012	12/31/2999
38240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	7/27/2009	12/31/2999
38308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lymphangiotomy or other operations on lymphatic channels	12/1/2014	12/31/2999
41530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	4/1/2024	12/31/2999
42140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Uvulectomy, excision of uvula	12/15/2006	1/14/2026
42145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	1/1/1950	12/31/2999
42950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharyngoplasty (plastic or reconstructive operation on pharynx)	3/15/2024	12/31/2999
43192	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	11/15/2007	12/31/2999
43206	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagoscopy, flexible, transoral; with optical endomicroscopy	12/15/2014	12/31/2999
43210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	7/15/2016	12/31/2999
43252	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	9/1/2020	12/31/2999
43253	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/1/2010	12/31/2999
43281	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	1/1/2026	12/31/2999
43284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	1/1/2017	12/31/2999
43285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of esophageal sphincter augmentation device	6/5/2018	12/31/2999
43289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted laparoscopy procedure, esophagus	6/1/2017	12/31/2999
43290	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	1/1/2023	12/31/2999
43291	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43332	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43333	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43334	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43335	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43336	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43337	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with gastrojejunostomy	6/1/2023	12/31/2999
43633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	7/1/2007	12/31/2999
43634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with formation of intestinal pouch	1/1/2026	12/31/2999
43644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	1/1/2005	12/31/2999
43645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	11/15/2019	12/31/2999
43770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	1/1/2006	12/31/2999
43771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	1/1/2006	12/31/2999
43772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43773	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	1/1/2006	12/31/2999
43774	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	1/1/2006	12/31/2999
43775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	7/1/2010	12/31/2999
43820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrojejunostomy; without vagotomy	1/1/2026	12/31/2999
43842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	9/1/2020	12/31/2999
43843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	1/1/1950	12/31/2999
43845	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/15/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	1/1/1950	12/31/2999
43847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	9/1/2020	12/31/2999
43848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	1/1/1950	12/31/2999
43860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	2/15/2022	12/31/2999
43865	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	1/1/2026	12/31/2999
43886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; revision of subcutaneous port component only	1/1/2006	12/31/2999
43887	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; removal of subcutaneous port component only	1/1/2006	12/31/2999
43888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43889	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed	1/1/2026	12/31/2999
44705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of fecal microbiota for instillation, including assessment of donor specimen	1/1/2013	12/31/2999
46707	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	9/1/2020	12/31/2999
47370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	1/1/1950	12/31/2999
47380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, open, of 1 or more liver tumor(s); radiofrequency	1/1/1950	12/31/2999
47381	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, open, of 1 or more liver tumor(s); cryosurgical	9/1/2020	12/31/2999
47382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	1/1/1950	12/31/2999
47384	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	1/1/2026	12/31/2999
48160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
49412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	10/3/2016	12/31/2999
50250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	6/1/2008	12/31/2999
50360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renal allotransplantation, implantation of graft; without recipient nephrectomy	2/15/2017	12/31/2999
50542	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	1/1/2003	12/31/2999
50592	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	1/1/2006	12/31/2999
50593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	6/1/2008	12/31/2999
51715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	5/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
51721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
52284	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2024	12/31/2999
52287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	1/1/2013	12/31/2999
52327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	6/1/2017	12/31/2999
52441	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	12/1/2015	12/31/2999
52442	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
52443	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed	1/1/2026	12/31/2999
53451	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	10/1/2024	12/31/2999
53452	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	10/1/2024	12/31/2999
53453	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; removal, each balloon	10/1/2024	12/31/2999
53454	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	10/1/2024	12/31/2999
53855	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of a temporary prostatic urethral stent, including urethral measurement	5/15/2024	12/31/2999

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53860	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	12/15/2014	12/31/2999
53865	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	1/1/2025	12/31/2999
53866	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	1/1/2025	12/31/2999
54110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision of penile plaque (Peyronie disease);	6/5/2018	12/31/2999
54111	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision of penile plaque (Peyronie disease); with graft to 5 cm in length	6/5/2018	12/31/2999
54112	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision of penile plaque (Peyronie disease); with graft greater than 5 cm in length	6/5/2018	12/31/2999
54125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputation of penis; complete	4/1/2008	12/31/2999
54200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for Peyronie disease;	12/15/2010	12/31/2999
54205	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for Peyronie disease; with surgical exposure of plaque	12/15/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54235	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	2/15/2007	12/31/2999
54240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile plethysmography	9/1/2020	12/31/2999
54360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Plastic operation on penis to correct angulation	3/15/2016	12/31/2999
54400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; non-inflatable (semi-rigid)	4/1/2008	12/31/2999
54401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; inflatable (self-contained)	4/1/2008	12/31/2999
54405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	4/1/2008	12/31/2999
54406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	6/1/2008	12/31/2999
54408	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of component(s) of a multi-component, inflatable penile prosthesis	2/15/2007	12/31/2999
54410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	2/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2007	12/31/2999
54415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	2/15/2007	12/31/2999
54416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	2/15/2007	12/31/2999
54417	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2007	12/31/2999
54440	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Plastic operation of penis for injury	1/1/2008	12/31/2999
54660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of testicular prosthesis (separate procedure)	4/1/2009	12/31/2999
55400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vasovasostomy, vasovasorrhaphy	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
55706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	11/15/2013	12/31/2999
55870	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electroejaculation	11/1/2015	12/31/2999
55873	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	6/15/2007	12/31/2999
55877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	1/1/2026	12/31/2999
55880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	2/1/2021	12/31/2999
55881	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
55882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2025	12/31/2999
55970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; male to female	4/1/2008	12/31/2999
55980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; female to male	4/1/2008	12/31/2999
56805	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Clitoroplasty for intersex state	4/1/2008	12/31/2999
56810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	6/1/2008	12/31/2999
57291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; without graft	4/1/2008	12/31/2999
57292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; with graft	4/1/2008	12/31/2999
57295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft; vaginal approach	4/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
57296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	1/1/2007	12/31/2999
57335	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vaginoplasty for intersex state	4/1/2008	12/31/2999
57426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	1/1/2010	12/31/2999
58321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Artificial insemination; intra-cervical	1/1/1950	12/31/2999
58322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Artificial insemination; intra-uterine	1/1/1950	12/31/2999
58323	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm washing for artificial insemination	1/1/1950	12/31/2999
58580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	1/1/2024	12/31/2999
58750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tubotubal anastomosis	1/1/1950	12/31/2999
58752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tubouterine implantation	1/1/1950	12/31/2999
58970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Follicle puncture for oocyte retrieval, any method	1/1/1950	12/31/2999
58974	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Embryo transfer, intrauterine	1/1/1950	12/31/2999
58976	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gamete, zygote, or embryo intrafallopian transfer, any method	1/1/1950	12/31/2999
59072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal umbilical cord occlusion, including ultrasound guidance	10/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
59074	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	12/1/2022	12/31/2999
59076	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal shunt placement, including ultrasound guidance	11/1/2012	12/31/2999
59897	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	6/1/2017	12/31/2999
60660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	1/1/2025	12/31/2999
60661	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
60699	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, endocrine system	10/1/2022	12/31/2999
61215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter	3/1/2007	12/31/2999
61630	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	2/1/2024	12/31/2999
61715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target intracranial, including stereotactic navigation and frame placement, when performed	1/1/2025	12/31/2999
61736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/1/2022	12/31/2999
61737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	5/1/2022	12/31/2999
61889	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	1/1/2024	12/31/2999
61892	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	1/1/2024	12/31/2999
62263	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/1/2022	12/31/2999
62264	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/1/2022	12/31/2999
62268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous aspiration, spinal cord cyst or syrinx	2/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
62287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Decompression, 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	1/1/2023	12/31/2999
62330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar	1/1/2026	12/31/2999
62331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
63032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
63266	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	2/1/2025	12/31/2999
63268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	2/1/2025	12/31/2999
63271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	2/1/2025	12/31/2999
63273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	2/1/2025	12/31/2999
63276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	2/1/2025	12/31/2999
63278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	2/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
63295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	2/1/2025	12/31/2999
64505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, anesthetic agent; sphenopalatine ganglion	9/1/2020	12/31/2999
64555	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	5/15/2025	12/31/2999
64566	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	8/1/2011	12/31/2999
64567	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	1/1/2026	12/31/2999
64568	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	1/1/2011	12/31/2999
64575	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	7/15/2023	12/31/2999
64582	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	5/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64583	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	5/1/2022	12/31/2999
64584	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	5/1/2022	12/31/2999
64590	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
64596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	1/1/2024	12/31/2999
64597	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64598	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	1/1/2024	12/31/2999
64615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	1/1/2013	12/31/2999
64620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, intercostal nerve	2/15/2025	12/31/2999
64624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	2/1/2023	12/31/2999
64628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	12/1/2025	12/31/2999
64629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	12/1/2025	12/31/2999
64640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent; other peripheral nerve or branch	4/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64650	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemodenervation of eccrine glands; both axillae	1/1/2006	12/31/2999
64653	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	1/1/2006	12/31/2999
64654	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (ie, total system), and intraoperative interrogation and programming	1/1/2026	12/31/2999
64655	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only	1/1/2026	12/31/2999
64656	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only	1/1/2026	12/31/2999
64657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator	1/1/2026	12/31/2999
64658	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; lead only	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64659	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; pulse generator only	1/1/2026	12/31/2999
64802	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy, cervical	12/15/2015	12/31/2999
64804	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy, cervicothoracic	12/15/2015	12/31/2999
64809	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy, thoracolumbar	12/15/2015	12/31/2999
64818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy, lumbar	11/1/2011	12/31/2999
64820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy; digital arteries, each digit	12/15/2015	12/31/2999
64823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sympathectomy; superficial palmar arch	12/15/2015	12/31/2999
65710	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); anterior lamellar	7/15/2008	12/31/2999
65730	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	7/15/2008	12/31/2999
65750	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); penetrating (in aphakia)	7/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
65755	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	7/15/2008	12/31/2999
65756	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); endothelial	1/1/2009	12/31/2999
65757	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	1/1/2015	12/31/2999
65760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Keratomileusis	1/1/2021	12/31/2999
65765	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Keratophakia	1/1/2021	12/31/2999
65767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epikeratoplasty	4/15/2008	12/31/2999
65770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoprosthesis	9/24/2012	12/31/2999
65771	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Radial keratotomy	1/1/2021	12/31/2999
65772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Corneal relaxing incision for correction of surgically induced astigmatism	1/1/2015	12/31/2999
65775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Corneal wedge resection for correction of surgically induced astigmatism	1/1/2015	12/31/2999
65778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of amniotic membrane on the ocular surface; without sutures	7/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
66174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	8/15/2012	12/31/2999
66175	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	8/15/2012	12/31/2999
66179	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	1/1/2015	12/31/2999
66180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	6/5/2018	12/31/2999
66183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	1/1/2014	12/31/2999
66184	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	6/5/2018	12/31/2999
66185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	6/5/2018	12/31/2999
67027	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	6/15/2011	12/31/2999
67028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravitreal injection of a pharmacologic agent (separate procedure)	7/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)	1/1/1950	12/31/2999
67225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/1950	12/31/2999
67516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suprachoroidal space injection of pharmacologic agent (separate procedure)	2/15/2024	12/31/2999
67901	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	4/1/2009	12/31/2999
67902	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	4/1/2009	12/31/2999
67903	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	4/1/2009	12/31/2999
67904	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	4/1/2009	12/31/2999
67906	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67908	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	4/1/2009	12/31/2999
69090	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ear piercing	9/24/2012	12/31/2999
69300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Otoplasty, protruding ear, with or without size reduction	4/1/2009	12/31/2999
69676	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tympanic neurectomy	11/1/2011	12/31/2999
69705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	1/15/2021	12/31/2999
69706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	1/15/2021	12/31/2999
69716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	12/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69719	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	12/15/2022	12/31/2999
69728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2023	12/31/2999
69729	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69730	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2023	12/31/2999
75577	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
75580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999
75894	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	2/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
76497	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted computed tomography procedure (eg, diagnostic, interventional)	4/1/2021	12/31/2999
76498	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	4/1/2021	12/31/2999
76948	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	1/1/2005	12/31/2999
77299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, therapeutic radiology clinical treatment planning	10/3/2016	12/31/2999
77399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	10/3/2016	12/31/2999
77499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, therapeutic radiology treatment management	10/3/2016	12/31/2999
77799	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, clinical brachytherapy	10/3/2016	12/31/2999
78434	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	9/15/2020	12/31/2999
79445	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiopharmaceutical therapy, by intra-arterial particulate administration	2/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	1/1/2013	12/31/2999
81206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	11/15/2013	12/31/2999
81207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	11/15/2013	12/31/2999
81241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	9/24/2012	12/31/2999
81243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	1/1/2012	12/31/2999
81535	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81536	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/1/2020	12/31/2999
81538	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	10/3/2016	12/31/2999
81599	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted multianalyte assay with algorithmic analysis	10/3/2016	12/31/2999
82523	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Collagen cross links, any method	12/15/2014	12/31/2999
83695	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein (a)	12/15/2014	12/31/2999
83698	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
83701	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	1/15/2015	12/31/2999
83704	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed	1/15/2015	12/31/2999
83722	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, direct measurement; small dense LDL cholesterol	1/1/2019	12/31/2999
83937	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Osteocalcin (bone g1a protein)	12/15/2014	12/31/2999
84112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/15/2015	12/31/2999
84999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted chemistry procedure	10/3/2016	12/31/2999
86001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allergen specific IgG quantitative or semiquantitative, each allergen	12/1/2020	12/31/2999

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86328	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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])	6/1/2023	12/31/2999
86343	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Leukocyte histamine release test (LHR)	12/1/2020	12/31/2999
86352	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)	1/1/2012	12/31/2999
86353	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	7/1/2007	12/31/2999
86408	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen	6/1/2023	12/31/2999
86409	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer	6/1/2023	12/31/2999
86413	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative	6/1/2023	12/31/2999
86769	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	6/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
86910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood typing, for paternity testing, per individual; ABO, Rh and MN	1/1/1950	12/31/2999
86950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leukocyte transfusion	4/1/2010	12/31/2999
87505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/15/2020	12/31/2999
87506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/15/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
87507	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/15/2020	12/31/2999
88375	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	12/15/2014	12/31/2999
89250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Culture of oocyte(s)/embryo(s), less than 4 days;	9/1/2020	12/31/2999
89251	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	9/1/2020	12/31/2999
89253	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Assisted embryo hatching, microtechniques (any method)	9/1/2020	12/31/2999
89254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oocyte identification from follicular fluid	1/1/1950	12/31/2999
89255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Preparation of embryo for transfer (any method)	1/1/1950	12/31/2999
89257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm identification from aspiration (other than seminal fluid)	1/1/1950	12/31/2999
89258	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; embryo(s)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
89259	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; sperm	1/1/1950	12/31/2999
89260	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	1/1/1950	12/31/2999
89261	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	1/1/1950	12/31/2999
89264	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm identification from testis tissue, fresh or cryopreserved	1/1/1950	12/31/2999
89268	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Insemination of oocytes	1/1/1950	12/31/2999
89272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extended culture of oocyte(s)/embryo(s), 4-7 days	1/1/1950	12/31/2999
89280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	1/1/1950	12/31/2999
89281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	1/1/1950	12/31/2999
89290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	3/1/2012	12/31/2999
89291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	3/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
89325	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm antibodies	1/1/1950	12/31/2999
89329	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation; hamster penetration test	1/1/1950	12/31/2999
89330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	11/1/2015	12/31/2999
89331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	11/1/2015	12/31/2999
89335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, reproductive tissue, testicular	1/1/1950	12/31/2999
89337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, mature oocyte(s)	1/1/2019	12/31/2999
89342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); embryo(s)	1/1/1950	12/31/2999
89343	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); sperm/semen	1/1/1950	12/31/2999
89344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); reproductive tissue, testicular/ovarian	1/1/1950	12/31/2999
89346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); oocyte(s)	1/1/1950	12/31/2999
89352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; embryo(s)	1/1/1950	12/31/2999
89353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; sperm/semen, each aliquot	1/1/1950	12/31/2999
89354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	1/1/1950	12/31/2999
89356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; oocytes, each aliquot	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90584	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use	7/1/2022	12/31/2999
90589	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chikungunya virus vaccine, live attenuated, for intramuscular use	8/22/2025	12/31/2999
90612	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, trivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 31.7 mcg/0.32 mL dosage, for intramuscular use	7/1/2025	12/31/2999
90613	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 40 mcg/0.4 mL dosage, for intramuscular use	7/1/2025	12/31/2999
90624	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	10/1/2024	12/31/2999
90626	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use	7/1/2021	12/31/2999
90627	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90637	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage, for intramuscular use	7/1/2024	12/31/2999
90638	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage, for intramuscular use	7/1/2024	12/31/2999
90664	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use	9/1/2020	12/31/2999
90666	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use	9/1/2020	12/31/2999
90667	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	9/1/2020	12/31/2999
90759	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use	1/1/2022	12/31/2999
90867	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	9/24/2012	12/31/2999
90868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90869	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	9/24/2012	12/31/2999
90875	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/24/2012	12/31/2999
90876	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	9/24/2012	12/31/2999
90885	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	1/1/2005	12/31/2999
90889	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90901	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biofeedback training by any modality	9/24/2012	12/31/2999
90912	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2021	12/31/2999
90913	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2021	12/31/2999
91034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	6/1/2007	12/31/2999
91035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	6/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
91037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	6/1/2007	12/31/2999
91038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	6/1/2007	12/31/2999
91065	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	12/1/2020	12/31/2999
91110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	1/1/2004	12/31/2999
91111	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	12/1/2020	12/31/2999
91112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
91113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	1/1/2023	12/31/2999
91117	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	12/1/2020	12/31/2999
91132	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrogastrography, diagnostic, transcutaneous;	12/15/2014	12/31/2999
91133	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrogastrography, diagnostic, transcutaneous; with provocative testing	12/15/2014	12/31/2999
92065	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Orthoptic training; performed by a physician or other qualified health care professional	1/1/2019	12/31/2999
92066	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Orthoptic training; under supervision of a physician or other qualified health care professional	1/1/2023	12/31/2999
92132	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Scanning computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92145	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	12/1/2020	12/31/2999
92512	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal function studies (eg, rhinomanometry)	9/1/2020	12/31/2999
92517	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	5/15/2021	12/31/2999
92518	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	5/15/2021	12/31/2999
92519	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	5/15/2021	12/31/2999
92520	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	6/5/2018	12/31/2999
92548	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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;	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92549	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	12/1/2020	12/31/2999
92622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	1/1/2024	12/31/2999
92623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2024	12/31/2999
92640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis with programming of auditory brainstem implant, per hour	11/15/2008	12/31/2999
92972	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)	3/15/2008	12/31/2999
93025	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microvolt T-wave alternans for assessment of ventricular arrhythmias	11/15/2014	12/31/2999
93050	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation 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); without programming	1/1/2026	12/31/2999
93146	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation 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, including optimization of tolerated therapeutic level setting	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93150	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	5/15/2024	12/31/2999
93151	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999
93152	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	5/15/2024	12/31/2999
93153	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation without programming of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999
93228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2020	12/31/2999
93264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/1/2020	12/31/2999
93278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Signal-averaged electrocardiography (SAECG), with or without ECG	9/1/2020	1/14/2026

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93356	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	7/15/2022	12/31/2999
93580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	9/15/2007	12/31/2999
93644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2015	12/31/2999
93660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	5/15/2008	12/31/2999
93701	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bioimpedance-derived physiologic cardiovascular analysis	1/1/1950	12/31/2999
93702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	10/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93740	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Temperature gradient studies	9/1/2020	12/31/2999
93797	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	1/1/2005	12/31/2999
93798	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	1/1/2005	12/31/2999
93886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcranial Doppler study of the intracranial arteries; complete study	1/1/2008	12/31/2999
93888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcranial Doppler study of the intracranial arteries; limited study	1/1/2008	12/31/2999
93892	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection	1/1/2009	12/31/2999
93893	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection	1/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94014	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2020	12/31/2999
94015	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	9/1/2020	12/31/2999
94016	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	9/1/2020	12/31/2999
94669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical chest wall oscillation to facilitate lung function, per session	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94774	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2007	12/31/2999
94775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2007	12/31/2999
94776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2007	12/31/2999
94777	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95060	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ophthalmic mucous membrane tests	12/1/2020	12/31/2999
95065	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Direct nasal mucous membrane test	12/1/2020	12/31/2999
95700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	11/1/2020	12/31/2999
95706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	11/1/2020	12/31/2999
95707	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95708	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	11/1/2020	12/31/2999
95709	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	11/1/2020	12/31/2999
95710	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95711	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	11/1/2020	12/31/2999
95712	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	11/1/2020	12/31/2999
95713	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	11/1/2020	12/31/2999
95715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	11/1/2020	12/31/2999
95716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95717	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2020	12/31/2999
95719	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2020	12/31/2999
95723	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95724	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2020	12/31/2999
95725	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	11/1/2020	12/31/2999
95726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2020	12/31/2999
95782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	7/15/2022	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95811	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/15/2022	12/31/2999
95919	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	1/1/2023	12/31/2999
95954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	11/1/2020	12/31/2999
95957	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	9/1/2020	12/31/2999
95961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	8/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	8/1/2015	12/31/2999
95965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	4/1/2009	12/31/2999
95966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	4/1/2009	12/31/2999
95967	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	4/1/2009	12/31/2999
96000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	7/15/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96001	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	7/15/2010	12/31/2999
96002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	7/15/2010	12/31/2999
96004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/15/2010	12/31/2999
96547	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2024	12/31/2999
96567	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
96570	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96571	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/15/2008	12/31/2999
96573	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2018	12/31/2999
96574	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96912	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photochemotherapy; psoralens and ultraviolet A (PUVA)	8/15/2009	12/31/2999
96913	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2010	12/31/2999
96922	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excimer laser treatment for psoriasis; over 500 sq cm	10/15/2007	12/31/2999
97007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education	1/1/2026	12/31/2999
97008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period	1/1/2026	12/31/2999
97009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
97012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Application of a modality to 1 or more areas; traction, mechanical	5/1/2015	12/31/2999
97014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Application of a modality to 1 or more areas; electrical stimulation (unattended)	11/14/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97024	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of a modality to 1 or more areas; diathermy (eg, microwave)	7/1/2021	12/31/2999
97032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	11/14/2012	12/31/2999
97037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	1/1/2024	12/31/2999
97124	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97169	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97171	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97172	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2017	12/31/2999
97533	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	9/1/2020	12/31/2999
97537	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97545	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Work hardening/conditioning; initial 2 hours	9/1/2020	12/31/2999
97546	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
97605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999
97606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2015	12/31/2999
97608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2015	12/31/2999
97610	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	9/1/2020	12/31/2999
97810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3/15/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97811	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	3/15/2013	12/31/2999
97813	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	3/15/2013	12/31/2999
97814	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	3/15/2013	12/31/2999
98962	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/1950	12/31/2999
99026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospital mandated on call service; in-hospital, each hour	1/1/1950	12/31/2999
99027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospital mandated on call service; out-of-hospital, each hour	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	1/1/1950	12/31/2999
99075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical testimony	1/1/1950	12/31/2999
99080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	1/1/2005	12/31/2999
99082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unusual travel (eg, transportation and escort of patient)	1/1/1950	12/31/2999
99360	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	1/1/1950	12/31/2999
99450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99455	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2007	12/31/2999
99456	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ambulance service, outside state per mile, transport (medicaid only)	1/1/1950	12/31/2999
A0080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	1/1/1950	12/31/2999
A0090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	1/1/1950	12/31/2999
A0100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; taxi	1/1/1950	12/31/2999
A0110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and bus, intra or inter state carrier	1/1/1950	12/31/2999
A0120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	1/1/1950	12/31/2999
A0130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: wheel-chair van	1/1/1950	12/31/2999
A0140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and air travel (private or commercial) intra or inter state	1/1/1950	12/31/2999
A0160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: per mile - case worker or social worker	1/1/1950	12/31/2999
A0170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation ancillary: parking fees, tolls, other	1/1/1950	12/31/2999
A0180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging-recipient	1/1/1950	12/31/2999
A0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-recipient	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging escort	1/1/1950	12/31/2999
A0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-escort	5/3/2006	12/31/2999
A0420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ambulance waiting time (als or bls), one half (1/2) hour increments	1/1/1950	12/31/2999
A0430	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air services, transport, one way (fixed wing)	1/1/1950	12/31/2999
A0431	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air services, transport, one way (rotary wing)	1/1/1950	12/31/2999
A0432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers	4/2/2007	12/31/2999
A0435	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fixed wing air mileage, per statute mile	11/15/2007	12/31/2999
A0436	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rotary wing air mileage, per statute mile	11/15/2007	12/31/2999
A0888	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	1/1/1950	12/31/2999
A0998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT	12/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ambulance service	1/1/1950	12/31/2999
A2001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix ac, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirragen advanced wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellistem, 1 mg	4/15/2022	12/31/2999
A2005	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Microlyte matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2006	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novosorb synpath dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2007	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2008	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Theragenesis, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2009	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Symphony, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2010	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Apis, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2011	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supra sdrm, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
A2012	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Suprathel, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
A2013	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix fs, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
A2014	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Omeza collagen matrix, per 100 mg	4/1/2023	12/31/2999
A2015	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Phoenix wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2023	12/31/2999
A2016	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm b, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2023	12/31/2999
A2017	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm glove, each	4/1/2023	12/31/2999
A2018	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm c, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2023	12/31/2999
A2019	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3 marigen shield, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ac5 advanced wound system (ac5)	9/1/2023	12/31/2999
A2021	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
A2022	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovaburn or innovamatrix xl, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2023	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix pd, 1 mg	10/1/2023	12/31/2999
A2024	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Resolve matrix or xenopatch, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2025	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d, per cubic centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2026	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata minimatrix, 5 mg	4/1/2024	12/31/2999
A2027	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matriderm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
A2028	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Micromatrix flex, per mg	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2029	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirotract wound matrix sheet, per cubic centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
A2030	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d fibers, per milligram	9/15/2025	12/31/2999
A2031	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirodry wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
A2032	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad matrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
A2033	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad morcells, 4 milligrams	9/15/2025	12/31/2999
A2034	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Foundation drs solo, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
A2035	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex p or theracor p or allacor p, per milligram	9/15/2025	12/31/2999
A2036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cohealyx collagen dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
A2037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	G4derm plus, per milliliter	10/1/2025	12/31/2999
A2038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Marigen pacto, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Innovamatrix fd, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
A4100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-sheet form skin substitute, fda cleared as a device, not otherwise specified (list in addition to primary procedure)	4/1/2022	12/31/2999
A4335	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Incontinence supply; miscellaneous	10/24/2019	12/31/2999
A4341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each	11/15/2023	12/31/2999
A4342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each	11/15/2023	12/31/2999
A4421	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Ostomy supply; miscellaneous	1/1/1950	12/31/2999
A4438	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each	4/1/2024	12/31/2999
A4457	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enema tube, with or without adapter, any type, replacement only, each	1/1/2024	12/31/2999
A4458	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enema bag with tubing, reusable	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exsufflation belt, includes all supplies and accessories	1/1/2024	12/31/2999
A4520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	1/1/2005	12/31/2999
A4540	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	1/1/2026	12/31/2999
A4541	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monthly supplies for use of device coded at e0733	1/1/2024	12/31/2999
A4542	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
A4543	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	5/15/2025	12/31/2999
A4545	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month	10/1/2024	12/31/2999
A4553	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-disposable underpads, all sizes	1/1/2017	12/31/2999
A4555	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	6/15/2017	12/31/2999
A4560	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neuromuscular electrical stimulator (nmes), disposable, replacement only	1/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4575	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Topical hyperbaric oxygen chamber, disposable	12/1/2020	12/31/2999
A4593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller	5/15/2025	12/31/2999
A4594	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each	5/15/2025	12/31/2999
A4595	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electrical stimulator supplies, 2 lead, per month, (e. G. Tens, nmes)	1/25/2013	12/31/2999
A4596	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system supplies and accessories, per month	4/1/2023	12/31/2999
A4600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	7/1/2008	12/31/2999
A4630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REPLACEMENT BATTERIES, MEDICALLY NECESSARY, TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT	4/15/2007	12/31/2999
A4638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement battery for patient-owned ear pulse generator, each	9/1/2020	12/31/2999
A4639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement pad for infrared heating pad system, each	1/15/2026	12/31/2999
A4639	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement pad for infrared heating pad system, each	12/15/2014	1/14/2026

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4641	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, DIAGNOSTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A4649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Surgical supply; miscellaneous	1/1/1950	12/31/2999
A4660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	1/1/1950	12/31/2999
A4663	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure cuff only	1/1/1950	12/31/2999
A4913	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dialysis supplies, not otherwise specified	1/1/1950	12/31/2999
A4930	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gloves, sterile, per pair	1/1/1950	12/31/2999
A4931	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oral thermometer, reusable, any type, each	1/1/1950	12/31/2999
A4932	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rectal thermometer, reusable, any type, each	1/1/1950	12/31/2999
A5507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	1/1/1950	12/31/2999
A6000	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A6261	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6262	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6512	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compression burn garment, not otherwise classified	10/24/2019	12/31/2999
A6519	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for nighttime use, each	4/1/2025	12/31/2999
A6549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for daytime use, each	10/24/2019	12/31/2999
A6550	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	7/27/2009	12/31/2999
A6590	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	External urinary catheters; disposable, with wicking material, for use with suction pump, per month	4/1/2023	12/31/2999
A6591	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	External urinary catheter; non-disposable, for use with suction pump, per month	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A7020	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	1/1/2011	12/31/2999
A7025	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	1/1/2003	12/31/2999
A7026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	1/1/2003	12/31/2999
A7047	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oral interface used with respiratory suction pump, each	1/1/2014	12/31/2999
A7049	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Expiratory positive airway pressure intranasal resistance valve	9/1/2023	12/31/2999
A9150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-prescription drugs	1/1/1950	12/31/2999
A9152	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9153	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9153	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PEDICULOSIS (LICE INFESTATION) TREATMENT, TOPICAL, FOR ADMINISTRATION BY PATIENT/CARETAKER	1/1/2005	12/31/2999
A9270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-covered item or service	1/1/1950	12/31/2999
A9272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wound suction, disposable, includes dressing, all accessories and components, any type, each	11/1/2013	12/31/2999
A9273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	1/1/2021	12/31/2999
A9279	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED	1/1/2007	12/31/2999
A9280	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alert or alarm device, not otherwise classified	1/1/1950	12/31/2999
A9281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REACHING/GRABBING DEVICE, ANY TYPE, ANY LENGTH, EACH	1/1/2006	12/31/2999
A9291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	2/1/2024	12/31/2999
A9300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Exercise equipment	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9515	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Choline c-11, diagnostic, per study dose up to 20 millicuries	1/1/2017	12/31/2999
A9579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, NOT OTHERWISE SPECIFIED (NOS), per ml	10/24/2019	12/31/2999
A9580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES	1/1/2014	12/31/2999
A9582	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	IODINE I-123 IOBENGUANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES	8/1/2013	12/31/2999
A9588	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluciclovine f-18, diagnostic, 1 millicurie	1/1/2017	12/31/2999
A9596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie	7/1/2022	12/31/2999
A9597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9598	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9601	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flortaucipir f 18 injection, diagnostic, 1 millicurie	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluorodopa f-18, diagnostic, per millicurie	10/1/2022	12/31/2999
A9608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flotufolastat f 18, diagnostic, 1 millicurie	1/1/2024	12/31/2999
A9609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fludeoxyglucose f18 up to 15 millicuries	1/1/2024	12/31/2999
A9611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flurpiridaz f 18, diagnostic, 1 millicurie	4/1/2025	12/31/2999
A9616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide (gozellix), diagnostic, 1 millicurie	10/1/2025	12/31/2999
A9698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	NON-RADIOACTIVE CONTRAST IMAGING MATERIAL, NOT OTHERWISE CLASSIFIED, PER STUDY	1/1/2006	12/31/2999
A9699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, THERAPEUTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A9800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie	10/1/2022	12/31/2999
A9900	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply, accessory, and/or service component of another hcpcs code	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply or accessory, not otherwise specified	1/1/1950	12/31/2999
B4102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	1/1/2005	12/31/2999
B4103	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	1/1/2005	12/31/2999
B4104	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	1/1/2005	12/31/2999
B4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	9/1/2020	12/31/2999
B4149	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/1950	12/31/2999
B4152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/1950	12/31/2999
B4153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
B4154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
B4157	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999
B4158	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999
B4160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999
B4161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4162	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2005	12/31/2999
B4164	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix	7/27/2009	12/31/2999
B4168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 3. 5%, (500 ml = 1 unit) - homemix	7/27/2009	12/31/2999
B4172	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 5. 5% through 7%, (500 ml = 1 unit) - homemix	7/27/2009	12/31/2999
B4176	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 7% through 8. 5%, (500 ml = 1 unit) - homemix	7/27/2009	12/31/2999
B4178	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution: amino acid, greater than 8. 5% (500 ml = 1 unit) - homemix	7/27/2009	12/31/2999
B4180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml=1 unit) - homemix	7/27/2009	12/31/2999
B4185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4193	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix	7/27/2009	12/31/2999
B4197	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999
B4199	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix	7/27/2009	12/31/2999
B4216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) homemix per day	7/27/2009	12/31/2999
B4220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition supply kit; premix, per day	7/27/2009	12/31/2999
B4222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition supply kit; home mix, per day	7/27/2009	12/31/2999
B4224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition administration kit, per day	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B5000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix	7/27/2009	12/31/2999
B5100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix	7/27/2009	12/31/2999
B5200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix	7/27/2009	12/31/2999
B9004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition infusion pump, portable	7/27/2009	12/31/2999
B9006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition infusion pump, stationary	7/27/2009	12/31/2999
B9998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for enteral supplies	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for parenteral supplies	1/1/1950	12/31/2999
C1052	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hemostatic agent, gastrointestinal, topical	5/15/2021	12/31/2999
C1062	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	4/1/2021	12/31/2999
C1600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	1/1/2024	12/31/2999
C1605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	7/1/2024	12/31/2999
C1607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system	1/1/2026	12/31/2999
C1608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)	1/1/2026	12/31/2999
C1735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	10/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	10/15/2025	12/31/2999
C1737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	1/1/2025	12/31/2999
C1740	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leadless electrode, transmitter, battery (all implantable), for sequential left ventricular pacing	10/1/2025	12/31/2999
C1761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	12/31/2999
C1764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Event recorder, cardiac (implantable)	1/1/2019	12/31/2999
C1767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), non-rechargeable	6/5/2018	12/31/2999
C1778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, neurostimulator (implantable)	6/5/2018	12/31/2999
C1783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ocular implant, aqueous drainage assist device	3/15/2015	12/31/2999
C1787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient programmer, neurostimulator	6/5/2018	12/31/2999
C1816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receiver and/or transmitter, neurostimulator (implantable)	6/5/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1817	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Septal defect implant system, intracardiac	4/15/2014	12/31/2999
C1818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integrated keratoprosthesis	9/24/2012	12/31/2999
C1820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), with rechargeable battery and charging system	6/5/2018	12/31/2999
C1821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	11/15/2019	12/31/2999
C1822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	7/15/2023	12/31/2999
C1823	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	4/1/2022	12/31/2999
C1824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, cardiac contractility modulation (implantable)	3/15/2024	12/31/2999
C1825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	2/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	7/1/2023	12/31/2999
C1827	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	9/1/2023	12/31/2999
C1832	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autograft suspension, including cell processing and application, and all system components	5/15/2024	12/31/2999
C1889	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Implantable/insertable device, not otherwise classified	1/1/2017	12/31/2999
C2614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Probe, percutaneous lumbar discectomy	9/1/2020	12/31/2999
C2616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, yttrium-90, per source	5/1/2015	12/31/2999
C2624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	12/1/2019	12/31/2999
C2698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C2699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, NON-STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999
C7531	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999
C7534	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with atherectomy, includes angioplasty within the same vessel, when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C7535	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal stent placement(s), includes angioplasty within the same vessel, when performed, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999
C8002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	6/15/2025	12/31/2999
C8003	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
C8003	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	12/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9307	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, linvoseltamab-gcpt, 1 mg	1/1/2026	12/31/2999
C9308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, carboplatin (avyxa), 1 mg	1/1/2026	12/31/2999
C9354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter	12/1/2020	12/31/2999
C9356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	12/1/2020	12/31/2999
C9358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	12/1/2020	12/31/2999
C9360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	12/1/2020	12/31/2999
C9363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	5/15/2021	12/31/2999
C9364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Porcine implant, Permacol, per square centimeter	12/1/2020	12/31/2999
C9399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unclassified drugs or biologicals	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9734	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	10/15/2014	12/31/2999
C9739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	12/1/2015	12/31/2999
C9740	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	12/1/2015	12/31/2999
C9757	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/1/2022	12/31/2999
C9764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2021	12/31/2999
C9766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	5/15/2021	12/31/2999
C9767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	5/15/2021	12/31/2999
C9768	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	3/1/2021	12/31/2999
C9772	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9773	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/15/2021	12/31/2999
C9774	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	8/15/2021	12/31/2999
C9775	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	8/15/2021	12/31/2999
C9777	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy	8/15/2021	12/31/2999
C9780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance	10/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	2/1/2024	12/31/2999
C9785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	1/1/2026	12/31/2999
C9793	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9807	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	6/15/2025	12/31/2999
C9808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
C9809	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	3/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Water circulating motorized cold therapy device (e.g., iceman) including all system components (e.g. pads, console, disposable parts), 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)	1/1/2026	12/31/2999
C9898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiolabeled product provided during a hospital inpatient stay	1/1/2012	12/31/2999
C9899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	IMPLANTED PROSTHETIC DEVICE, PAYABLE ONLY FOR INPATIENTS WHO DO NOT HAVE INPATIENT COVERAGE	1/1/2012	12/31/2999
D0372	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? comprehensive series of radiographic images	1/1/2023	12/31/2999
D0373	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? bitewing radiographic image	1/1/2023	12/31/2999
D0374	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? periapical radiographic image	1/1/2023	12/31/2999
D0387	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? comprehensive series of radiographic images - image capture only	1/1/2023	12/31/2999
D0388	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? bitewing radiographic image - image capture only	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0389	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? periapical radiographic image - image capture only	1/1/2023	12/31/2999
D0396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D printing of a 3D dental surface scan	1/1/2024	12/31/2999
D0426	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	collection, preparation, and analysis of saliva sample - point-of-care	1/1/2026	12/31/2999
D0461	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	testing for cracked tooth	1/1/2026	12/31/2999
D0801	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D intraoral surface scan - direct	1/1/2023	12/31/2999
D0802	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D dental surface scan ? indirect	1/1/2023	12/31/2999
D0803	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D facial surface scan ? direct	1/1/2023	12/31/2999
D0804	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D facial surface scan ? indirect	1/1/2023	12/31/2999
D0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified diagnostic procedure, by report	10/24/2019	12/31/2999
D1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling	1/1/2024	12/31/2999
D1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified preventive procedure, by report	10/24/2019	12/31/2999
D2989	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	excavation of a tooth resulting in the determination of non-restorability	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	application of hydroxyapatite regeneration medicament - per tooth	1/1/2024	12/31/2999
D2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified restorative procedure, by report	10/24/2019	12/31/2999
D3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified endodontic procedure, by report	10/24/2019	12/31/2999
D4999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified periodontal procedure, by report	10/24/2019	12/31/2999
D5877	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	duplication of complete denture - maxillary	1/1/2026	12/31/2999
D5878	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	duplication of complete denture - mandibular	1/1/2026	12/31/2999
D5899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified removable prosthodontic procedure, by report	10/24/2019	12/31/2999
D5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified maxillofacial prosthesis, by report	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	1/1/2026	12/31/2999
D6105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of implant body not requiring bone removal nor flap elevation	1/1/2023	12/31/2999
D6196	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of an indirect restoration on an implant retained abutment	1/1/2026	12/31/2999
D6197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	1/1/2023	12/31/2999
D6199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified implant procedure, by report	10/24/2019	12/31/2999
D6280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch	1/1/2026	12/31/2999
D6999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified fixed prosthodontic procedure, by report	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7939	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	1/1/2024	12/31/2999
D7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified oral surgery procedure, by report	10/24/2019	12/31/2999
D8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified orthodontic procedure, by report	10/24/2019	12/31/2999
D9936	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of occlusal guard - per appliance	1/1/2026	12/31/2999
D9938	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fabrication of a custom removable clear plastic temporary aesthetic appliance	1/1/2024	12/31/2999
D9939	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	placement of a custom removable clear plastic temporary aesthetic appliance	1/1/2024	12/31/2999
D9954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	1/1/2024	12/31/2999
D9955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	oral appliance therapy (OAT) titration visit	1/1/2024	12/31/2999
D9956	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	administration of home sleep apnea test	1/1/2024	12/31/2999
D9957	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	screening for sleep related breathing disorders	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9959	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	unspecified sleep apnea services procedure, by report	1/1/2025	12/31/2999
D9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified adjunctive procedure, by report	1/1/1950	12/31/2999
E0152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Walker, battery powered, wheeled, folding, adjustable or fixed height	4/1/2024	12/31/2999
E0181	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWERED PRESSURE REDUCING MATTRESS OVERLAY/PAD, ALTERNATING, WITH PUMP, INCLUDES HEAVY DUTY	7/27/2009	12/31/2999
E0182	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PUMP FOR ALTERNATING PRESSURE PAD, FOR REPLACEMENT ONLY	7/27/2009	12/31/2999
E0183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty	10/1/2022	12/31/2999
E0184	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dry pressure mattress	7/27/2009	12/31/2999
E0185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gel or gel-like pressure pad for mattress, standard mattress length and width	7/27/2009	12/31/2999
E0186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Air pressure mattress	7/27/2009	12/31/2999
E0187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Water pressure mattress	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/1950	12/31/2999
E0193	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered air flotation bed (low air loss therapy)	7/27/2009	12/31/2999
E0194	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Air fluidized bed	7/27/2009	12/31/2999
E0196	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gel pressure mattress	7/27/2009	12/31/2999
E0201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile contracture device, manual, greater than 3 lbs traction force	4/1/2025	12/31/2999
E0217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Water circulating heat pad with pump	9/1/2020	12/31/2999
E0218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluid circulating cold pad with pump, any type	9/1/2020	12/31/2999
E0221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infrared heating pad system	1/15/2026	12/31/2999
E0221	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Infrared heating pad system	9/1/2020	1/14/2026
E0225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hydrocollator unit, includes pads	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0231	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover	12/15/2014	12/31/2999
E0232	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Warming card for use with the non contact wound warming device and non contact wound warming wound cover	12/15/2014	12/31/2999
E0236	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pump for water circulating pad	9/1/2020	12/31/2999
E0239	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hydrocollator unit, portable	9/1/2020	12/31/2999
E0240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath/shower chair, with or without wheels, any size	5/15/2021	12/31/2999
E0241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub wall rail, each	5/15/2021	12/31/2999
E0242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub rail, floor base	5/15/2021	12/31/2999
E0243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Toilet rail, each	5/15/2021	12/31/2999
E0244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Raised toilet seat	5/15/2021	12/31/2999
E0245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tub stool or bench	5/15/2021	12/31/2999
E0246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer tub rail attachment	5/15/2021	12/31/2999
E0247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer bench for tub or toilet with or without commode opening	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0248	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer bench, heavy duty, for tub or toilet with or without commode opening	5/15/2021	12/31/2999
E0249	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	9/1/2020	12/31/2999
E0250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, fixed height, with any type side rails, with mattress	5/15/2014	12/31/2999
E0251	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, fixed height, with any type side rails, without mattress	5/15/2014	12/31/2999
E0255	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	5/15/2014	12/31/2999
E0256	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	5/15/2014	12/31/2999
E0260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	4/15/2008	12/31/2999
E0261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	4/15/2008	12/31/2999
E0265	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	4/15/2008	12/31/2999
E0266	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	4/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress	9/1/2020	12/31/2999
E0271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mattress, innerspring	4/15/2008	12/31/2999
E0272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mattress, foam rubber	4/15/2008	12/31/2999
E0273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bed board	9/1/2020	12/31/2999
E0274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Over-bed table	9/1/2020	12/31/2999
E0277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered pressure-reducing air mattress	7/27/2009	12/31/2999
E0280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bed cradle, any type	4/15/2008	12/31/2999
E0290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, fixed height, without side rails, with mattress	5/15/2014	12/31/2999
E0291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, fixed height, without side rails, without mattress	5/15/2014	12/31/2999
E0292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, variable height, hi-lo, without side rails, with mattress	5/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, variable height, hi-lo, without side rails, without mattress	5/15/2014	12/31/2999
E0294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	4/15/2008	12/31/2999
E0295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	4/15/2008	12/31/2999
E0296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, total electric (head, foot and height adjustments). Without side rails, with mattress	4/15/2008	12/31/2999
E0297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress	4/15/2008	12/31/2999
E0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	9/1/2020	12/31/2999
E0301	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/15/2008	12/31/2999
E0302	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	4/15/2008	12/31/2999
E0303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	4/15/2008	12/31/2999
E0315	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bed accessory: board, table, or support device, any type	9/1/2020	12/31/2999
E0316	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Safety enclosure frame/canopy for use with hospital bed, any type	9/1/2020	12/31/2999
E0328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD,	9/24/2012	12/31/2999
E0329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES,	9/24/2012	12/31/2999
E0373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nonpowered advanced pressure reducing mattress	9/24/2012	12/31/2999
E0446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	10/24/2019	12/31/2999
E0468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0471	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/1/2022	12/31/2999
E0481	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intrapulmonary percussive ventilation system and related accessories	1/1/1950	12/31/2999
E0482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cough stimulating device, alternating positive and negative airway pressure	1/1/1950	12/31/2999
E0483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each	1/1/2003	12/31/2999
E0484	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oscillatory positive expiratory pressure device, non-electric, any type, each	1/1/2003	12/31/2999
E0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0486	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/2022	12/31/2999
E0487	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	12/15/2014	12/31/2999
E0490	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	10/1/2023	12/31/2999
E0491	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	10/1/2023	12/31/2999
E0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2024	12/31/2999
E0530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	1/1/2024	12/31/2999
E0616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable cardiac event recorder with memory, activator and programmer	6/15/2007	12/31/2999
E0617	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External defibrillator with integrated electrocardiogram analysis	12/1/2019	12/31/2999
E0620	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Skin piercing device for collection of capillary blood, laser, each	1/1/1950	12/31/2999
E0625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, bathroom or toilet, not otherwise classified	2/15/2010	12/31/2999
E0625	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient lift, bathroom or toilet, not otherwise classified	12/21/2004	12/31/2999
E0627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat lift mechanism, electric, any type	2/15/2010	12/31/2999
E0629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat lift mechanism, non-electric, any type	2/15/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, electric with seat or sling	9/1/2020	12/31/2999
E0636	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Multipositional patient support system, with integrated lift, patient accessible controls	9/24/2012	12/31/2999
E0637	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	1/1/2004	12/31/2999
E0638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	1/1/2004	12/31/2999
E0639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	9/24/2012	12/31/2999
E0640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, fixed system, includes all components/accessories	9/1/2020	12/31/2999
E0641	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	1/1/2006	12/31/2999
E0642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0650	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, non-segmental home model	1/1/1950	12/31/2999
E0651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, segmental home model without calibrated gradient pressure	7/1/2008	12/31/2999
E0652	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, segmental home model with calibrated gradient pressure	1/1/1950	12/31/2999
E0655	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	7/1/2008	12/31/2999
E0656	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	1/1/2009	12/31/2999
E0657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	1/1/2009	12/31/2999
E0658	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest	10/1/2025	12/31/2999
E0659	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest	10/1/2025	12/31/2999
E0660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	7/1/2008	12/31/2999
E0665	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0666	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	7/1/2008	12/31/2999
E0667	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, full leg	7/1/2008	12/31/2999
E0668	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, full arm	7/1/2008	12/31/2999
E0669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, half leg	7/1/2008	12/31/2999
E0670	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	7/15/2015	12/31/2999
E0671	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, full leg	7/1/2008	12/31/2999
E0672	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, full arm	7/1/2008	12/31/2999
E0673	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, half leg	7/1/2008	12/31/2999
E0675	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0676	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	1/1/2007	12/31/2999
E0676	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	3/20/2019	12/31/2999
E0677	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, trunk	4/1/2023	12/31/2999
E0678	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, full leg	1/1/2024	12/31/2999
E0679	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, half leg	1/1/2024	12/31/2999
E0680	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic compression controller with sequential calibrated gradient pressure	1/1/2024	12/31/2999
E0681	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic compression controller without calibrated gradient pressure	1/1/2024	12/31/2999
E0682	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, full arm	1/1/2024	12/31/2999
E0683	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic, non-sequential, peristaltic wave compression pump	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0691	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	1/15/2008	12/31/2999
E0692	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	1/15/2008	12/31/2999
E0693	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel	1/15/2008	12/31/2999
E0694	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection	1/15/2008	12/31/2999
E0705	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer device, any type, each	1/1/2006	12/31/2999
E0715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	10/1/2024	12/31/2999
E0716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	10/1/2024	12/31/2999
E0720	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION	1/25/2013	12/31/2999
E0721	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous electrical nerve stimulator for nerves in the auricular region	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0730	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	1/25/2013	12/31/2999
E0731	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Form fitting conductive garment for delivery of tens or nmes (with conductive fibers separated from the patient's skin by layers of fabric)	1/1/2021	12/31/2999
E0732	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system, any type	5/15/2024	12/31/2999
E0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	1/1/2024	12/31/2999
E0734	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
E0735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-invasive vagus nerve stimulator	1/1/2024	12/31/2999
E0736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous tibial nerve stimulator	4/1/2024	12/31/2999
E0737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous tibial nerve stimulator, controlled by phone application	10/1/2024	12/31/2999
E0738	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories	5/15/2025	1/8/2026

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors	4/1/2024	1/8/2026
E0740	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-implanted pelvic floor electrical stimulator, complete system	9/1/2020	12/31/2999
E0743	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External lower extremity nerve stimulator for restless legs syndrome, each	11/19/2025	12/31/2999
E0744	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromuscular stimulator for scoliosis	9/24/2012	12/31/2999
E0746	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electromyography (emg), biofeedback device	9/24/2012	12/31/2999
E0747	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	1/1/1950	12/31/2999
E0760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, low intensity ultrasound, non-invasive	1/1/1950	12/31/2999
E0761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	9/24/2012	12/31/2999
E0762	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0764	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	4/1/2022	12/31/2999
E0766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulation device used for cancer treatment, includes all accessories, any type	6/15/2017	12/31/2999
E0769	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	1/1/2005	12/31/2999
E0769	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	12/15/2014	12/31/2999
E0770	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	1/1/2009	12/31/2999
E0784	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External ambulatory infusion pump, insulin	1/1/1950	1/5/2026

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement	3/1/2007	12/31/2999
E0786	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)	3/1/2007	12/31/2999
E0787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing	7/1/2023	12/31/2999
E0830	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ambulatory traction device, all types, each	9/1/2020	12/31/2999
E0840	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction frame, attached to headboard, cervical traction	9/1/2020	12/31/2999
E0849	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	12/15/2014	12/31/2999
E0850	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction stand, free standing, cervical traction	9/1/2020	12/31/2999
E0855	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical traction equipment not requiring additional stand or frame	12/15/2014	12/31/2999
E0856	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical traction device, with inflatable air bladder(s)	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0860	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction equipment, overdoor, cervical	9/1/2020	12/31/2999
E0890	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction frame, attached to footboard, pelvic traction	12/15/2014	12/31/2999
E0920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame, attached to bed, includes weights	11/1/2005	12/31/2999
E0930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame, free standing, includes weights	11/1/2005	12/31/2999
E0935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY	1/1/1950	12/31/2999
E0936	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	12/1/2020	12/31/2999
E0941	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gravity assisted traction device, any type	11/1/2005	12/31/2999
E0942	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical head harness/halter	9/1/2020	12/31/2999
E0944	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pelvic belt/harness/boot	9/1/2020	12/31/2999
E0946	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster)	11/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0947	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame, attachments for complex pelvic traction	9/1/2020	12/31/2999
E0948	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame, attachments for complex cervical traction	9/1/2020	12/31/2999
E0950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, tray, each	9/15/2006	12/31/2999
E0953	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each	1/1/2018	12/31/2999
E0954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot	1/1/2018	12/31/2999
E0955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	9/15/2006	12/31/2999
E0969	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Narrowing device, wheelchair	3/15/2014	12/31/2999
E0981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, seat upholstery, replacement only, each	9/15/2006	12/31/2999
E0982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, back upholstery, replacement only, each	9/15/2006	12/31/2999
E0983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	7/27/2009	12/31/2999
E0985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, seat lift mechanism	3/15/2014	12/31/2999
E0986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power assist system	3/15/2014	12/31/2999
E0988	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	3/15/2014	12/31/2999
E0990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, elevating leg rest, complete assembly, each	3/15/2014	12/31/2999
E0992	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid seat insert	9/15/2006	12/31/2999
E1002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, tilt only	9/15/2006	12/31/2999
E1003	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, recline only, without shear reduction	9/15/2006	12/31/2999
E1004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	9/15/2006	12/31/2999
E1005	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seatng system, recline only, with power shear reduction	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	9/15/2006	12/31/2999
E1007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	9/15/2006	12/31/2999
E1008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	9/15/2006	12/31/2999
E1009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	9/15/2006	12/31/2999
E1010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	9/15/2006	12/31/2999
E1012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	1/1/2016	12/31/2999
E1022	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair transportation securement system, any type includes all components and accessories	4/1/2025	12/31/2999
E1023	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair transit securement system, includes all components and accessories	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other	3/15/2014	12/31/2999
E1032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface	4/1/2025	12/31/2999
E1033	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type	4/1/2025	12/31/2999
E1034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type	4/1/2025	12/31/2999
E1035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	3/15/2014	12/31/2999
E1036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS	9/15/2006	12/31/2999
E1050	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1060	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating legrests	3/15/2014	12/31/2999
E1070	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable footrest	3/15/2014	12/31/2999
E1083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest	3/15/2014	12/31/2999
E1084	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1085	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	3/15/2014	12/31/2999
E1086	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair detachable arms desk or full length, swing away detachable footrests	3/15/2014	12/31/2999
E1087	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1088	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1089	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, fixed length arms, swing away detachable footrest	3/15/2014	12/31/2999
E1090	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests	3/15/2014	12/31/2999
E1092	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1093	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable footrests	3/15/2014	12/31/2999
E1100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Semi-reclining wheelchair, detachable arms (desk or full length) elevating leg rest	3/15/2014	12/31/2999
E1130	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	3/15/2014	12/31/2999
E1140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, detachable arms, desk or full length, swing away detachable footrests	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, detachable arms, desk or full length swing away detachable elevating legrests	3/15/2014	12/31/2999
E1160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, fixed full length arms, swing away detachable elevating legrests	3/15/2014	12/31/2999
E1161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual adult size wheelchair, includes tilt in space	3/15/2014	12/31/2999
E1170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests	3/15/2014	12/31/2999
E1171	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, without footrests or legrest	3/15/2014	12/31/2999
E1172	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest	3/15/2014	12/31/2999
E1180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests	3/15/2014	12/31/2999
E1190	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating legrests	3/15/2014	12/31/2999
E1195	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests	12/1/2011	12/31/2999
E1200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, swing away detachable footrest	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification	9/15/2006	12/31/2999
E1221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with fixed arm, footrests	3/15/2014	12/31/2999
E1222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with fixed arm, elevating legrests	3/15/2014	12/31/2999
E1223	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with detachable arms, footrests	3/15/2014	12/31/2999
E1224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with detachable arms, elevating legrests	3/15/2014	12/31/2999
E1225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	3/15/2014	12/31/2999
E1226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	9/15/2006	12/31/2999
E1227	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special height arms for wheelchair	3/15/2014	12/31/2999
E1228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special back height for wheelchair	3/15/2014	12/31/2999
E1229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1229	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power operated vehicle (three or four wheel nonhighway) specify brand name and model number	1/1/1950	12/31/2999
E1231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	3/15/2014	12/31/2999
E1232	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	3/15/2014	12/31/2999
E1233	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	3/15/2014	12/31/2999
E1234	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	3/15/2014	12/31/2999
E1235	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, rigid, adjustable, with seating system	3/15/2014	12/31/2999
E1236	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, folding, adjustable, with seating system	3/15/2014	12/31/2999
E1237	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, rigid, adjustable, without seating system	3/15/2014	12/31/2999
E1238	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, folding, adjustable, without seating system	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1239	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	3/15/2014	12/31/2999
E1239	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest	3/15/2014	12/31/2999
E1250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, fixed full length arms, swing away detachable footrest	3/15/2014	12/31/2999
E1260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest	3/15/2014	12/31/2999
E1270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests	3/15/2014	12/31/2999
E1280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, detachable arms (desk or full length) elevating legrests	9/15/2006	12/31/2999
E1285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	9/15/2006	12/31/2999
E1290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest	9/15/2006	12/31/2999
E1295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, elevating legrest	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat height from floor	3/15/2014	12/31/2999
E1297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat depth, by upholstery	3/15/2014	12/31/2999
E1298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat depth and/or width, by construction	3/15/2014	12/31/2999
E1300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, portable (overtub type)	1/1/1950	12/31/2999
E1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool tub, walk-in, portable	1/1/2024	12/31/2999
E1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, non-portable (built-in type)	1/1/1950	12/31/2999
E1399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Durable medical equipment, miscellaneous	1/15/2015	12/31/2999
E1629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tablo hemodialysis system for the billable dialysis service	1/1/2022	12/31/2999
E1632	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wearable artificial kidney, each	1/1/2023	12/31/2999
E1639	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scale, each	1/1/2024	12/31/2999
E1699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dialysis equipment, not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Jaw motion rehabilitation system	7/1/2024	12/31/2999
E1701	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	7/1/2024	12/31/2999
E1702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	7/1/2024	12/31/2999
E1902	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Communication board, non-electronic augmentative or alternative communication device	1/1/1950	12/31/2999
E1905	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Virtual reality cognitive behavioral therapy device (cbt), including pre-programmed therapy software	4/1/2023	12/31/2999
E2120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	9/1/2020	12/31/2999
E2201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	9/15/2006	12/31/2999
E2202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches	9/15/2006	12/31/2999
E2203	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	9/15/2006	12/31/2999
E2204	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each	9/15/2006	12/31/2999
E2207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	9/1/2020	12/31/2999
E2209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	3/15/2014	12/31/2999
E2211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2212	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2214	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2219	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	9/15/2006	12/31/2999
E2220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each	9/15/2006	12/31/2999
E2221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	9/15/2006	12/31/2999
E2222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	9/15/2006	12/31/2999
E2228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	1/1/2008	12/31/2999
E2230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	1/1/2009	12/31/2999
E2231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	1/1/2009	12/31/2999
E2291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Back, planar, for pediatric size wheelchair including fixed attaching hardware	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	9/15/2006	12/31/2999
E2293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	9/15/2006	12/31/2999
E2294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	9/15/2006	12/31/2999
E2295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	1/1/2009	12/31/2999
E2298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	4/1/2024	12/31/2999
E2301	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power standing system, any type	9/1/2020	12/31/2999
E2310	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999
E2312	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL	7/27/2009	12/31/2999
E2313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,	7/27/2009	12/31/2999
E2321	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	3/15/2014	12/31/2999
E2322	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	9/15/2006	12/31/2999
E2323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2324	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, chin cup for chin control interface	9/15/2006	12/31/2999
E2325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	9/15/2006	12/31/2999
E2326	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, breath tube kit for sip and puff interface	9/15/2006	12/31/2999
E2327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	9/15/2006	12/31/2999
E2328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	9/15/2006	12/31/2999
E2329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/15/2006	12/31/2999
E2331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	9/24/2012	12/31/2999
E2340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	9/15/2006	12/31/2999
E2341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	9/15/2006	12/31/2999
E2342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	9/15/2006	12/31/2999
E2343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	9/15/2006	12/31/2999
E2351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	9/15/2006	12/31/2999
E2358	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2359	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	1/1/2012	12/31/2999
E2360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, 22 nf non-sealed lead acid battery, each	9/15/2006	12/31/2999
E2361	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat)	9/15/2006	12/31/2999
E2362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	9/15/2006	12/31/2999
E2363	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	9/15/2006	12/31/2999
E2364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	9/15/2006	12/31/2999
E2365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	9/15/2006	12/31/2999
E2366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	9/15/2006	12/31/2999
E2367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	9/15/2006	12/31/2999
E2372	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	9/15/2006	12/31/2999
E2373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	3/15/2014	12/31/2999
E2374	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	3/15/2014	12/31/2999
E2375	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	3/15/2014	12/31/2999
E2376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2377	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	3/15/2014	12/31/2999
E2397	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	7/27/2009	12/31/2999
E2402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy electrical pump, stationary or portable	7/27/2009	12/31/2999
E2500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	1/1/2004	12/31/2999
E2502	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	1/1/2004	12/31/2999
E2504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	1/1/2004	12/31/2999
E2506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	1/1/2004	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	1/1/2004	12/31/2999
E2510	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	1/1/2004	12/31/2999
E2511	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating software program, for personal computer or personal digital assistant	1/1/2004	12/31/2999
E2512	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessory for speech generating device, mounting system	1/1/2004	12/31/2999
E2513	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Accessory for speech generating device, electromyographic sensor	10/1/2024	12/31/2999
E2599	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessory for speech generating device, not otherwise classified	12/1/2007	12/31/2999
E2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Accessory for speech generating device, not otherwise classified	1/1/1950	12/31/2999
E2603	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	9/15/2006	12/31/2999
E2604	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	9/15/2006	12/31/2999
E2606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	9/15/2006	12/31/2999
E2607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	9/15/2006	12/31/2999
E2608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	9/15/2006	12/31/2999
E2609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	9/15/2006	12/31/2999
E2610	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR SEAT CUSHION, POWERED	9/1/2020	12/31/2999
E2613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2617	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	9/15/2006	12/31/2999
E2622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2011	12/31/2999
E2623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2011	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2011	12/31/2999
E2625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2011	12/31/2999
E2626	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	3/15/2014	12/31/2999
E2627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	3/15/2014	12/31/2999
E2628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	3/15/2014	12/31/2999
E2629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2630	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	3/15/2014	12/31/2999
E2631	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	3/15/2014	12/31/2999
E2632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	3/15/2014	12/31/2999
E2633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	3/15/2014	12/31/2999
E3000	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech volume modulation system, any type, including all components and accessories	5/15/2024	12/31/2999
E3200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only	10/1/2024	12/31/2999
E8000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	1/5/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0138	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2024	12/31/2999
G0166	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External counterpulsation, per treatment session	9/24/2012	12/31/2999
G0176	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2008	12/31/2999
G0177	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	9/15/2011	12/31/2999
G0235	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Pet imaging, any site, not otherwise specified	10/24/2019	12/31/2999
G0255	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve	12/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2015	12/31/2999
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).	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	9/1/2020	12/31/2999
G0282	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in g0281	9/1/2020	12/31/2999
G0283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	10/15/2016	12/31/2999
G0293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	1/1/1950	12/31/2999
G0295	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses	12/15/2014	12/31/2999
G0302	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pre-operative pulmonary surgery services for preparation for lvrs, complete course of services, to include a minimum of 16 days of services	1/1/2004	12/31/2999
G0303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pre-operative pulmonary surgery services for preparation for lvrs, 10 to 15 days of services	1/1/2004	12/31/2999
G0304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pre-operative pulmonary surgery services for preparation for lvrs, 1 to 9 days of services	1/1/2004	12/31/2999
G0305	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Post-discharge pulmonary surgery services after lvrs, minimum of 6 days of services	1/1/2004	12/31/2999
G0310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	5/11/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	5/11/2022	12/31/2999
G0312	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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, 5 to 15 mins time (this code is used for medicaid billing purposes)	5/11/2022	12/31/2999
G0313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	5/11/2022	12/31/2999
G0314	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	5/11/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	5/11/2022	12/31/2999
G0316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0318	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99345, 99350 for home or residence evaluation and management services). (do not report g0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (do not report g0318 for any time unit less than 15 minutes)	1/1/2023	12/31/2999
G0329	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2023	12/31/2999
G0341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	7/27/2009	12/31/2999
G0342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	7/27/2009	12/31/2999
G0343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	7/27/2009	12/31/2999
G0372	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHYSICIAN SERVICE REQUIRED TO ESTABLISH AND DOCUMENT THE NEED FOR A POWER MOBILITY DEVICE (USE IN ADDITION TO PRIMARY EVALUATION AND MANAGEMENT CODE)	10/25/2005	12/31/2999
G0422	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION	12/1/2019	12/31/2999
G0423	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION	12/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0428	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	12/1/2020	12/31/2999
G0429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	9/24/2012	12/31/2999
G0448	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2012	12/31/2999
G0455	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen	1/1/2013	12/31/2999
G0460	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0465	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	4/1/2022	12/31/2999
G0516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)	1/1/2018	12/31/2999
G0518	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	1/1/2018	12/31/2999
G0552	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	6/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0553	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	6/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0554	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	6/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0556	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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,	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0557	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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,	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0558	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0561	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2025	12/31/2999
G2011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes	1/1/2019	12/31/2999
G2082	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	8/1/2021	12/31/2999
G2083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	8/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G3002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G3003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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.)	1/1/2023	12/31/2999
G8395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	1/1/2008	12/31/2999
G8396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	1/1/2008	12/31/2999
G8397	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	1/1/2008	12/31/2999
G8399	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed	1/1/2008	12/31/2999
G8400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given	1/1/2008	12/31/2999
G8404	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	1/1/2008	12/31/2999
G8405	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	1/1/2008	12/31/2999
G8410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION WAS NOT PERFORMED	1/1/2008	12/31/2999
G8416	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR	1/1/2008	12/31/2999
G8417	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented above normal parameters and a follow-up plan is documented	1/1/2008	12/31/2999
G8418	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented below normal parameters and a follow-up plan is documented	1/1/2008	12/31/2999
G8419	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	1/1/2008	12/31/2999
G8420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented within normal parameters and no follow-up plan is required	1/1/2008	12/31/2999
G8421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented and no reason is given	1/1/2008	12/31/2999
G8427	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	1/1/2008	12/31/2999
G8428	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status)	1/1/2008	12/31/2999
G8431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression is documented as being positive and a follow-up plan is documented	1/1/2008	12/31/2999
G8432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Depression screening not documented, reason not given	1/1/2008	12/31/2999
G8433	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression not completed, documented patient or medical reason	1/1/2008	12/31/2999
G8450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy prescribed	1/1/2008	12/31/2999
G8451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2008	12/31/2999
G8452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy not prescribed	1/1/2008	12/31/2999
G8465	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High or very high risk of recurrence of prostate cancer	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8473	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	1/1/2008	12/31/2999
G8474	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2008	12/31/2999
G8475	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	1/1/2008	12/31/2999
G8476	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	1/1/2008	12/31/2999
G8477	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	1/1/2008	12/31/2999
G8478	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure measurement not performed or documented, reason not given	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Other specified case management service not elsewhere classified	10/24/2019	12/31/2999
G9050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9053	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9054	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9055	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	10/24/2019	12/31/2999
G9055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9056	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9061	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9062	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9063	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9064	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9066	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9072	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9073	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9074	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9077	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9078	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9079	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9083	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9084	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9085	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9086	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9087	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9088	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9089	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9092	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9093	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9094	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9095	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9096	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9097	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9098	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9099	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9103	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9104	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9106	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9107	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9123	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9124	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999
G9128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage i (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9129	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	10/1/2007	12/31/2999
G9147	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9886	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	1/1/2024	12/31/2999
G9887	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	1/1/2024	12/31/2999
G9888	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Maintenance 5% wl from baseline weight in months 7-12	1/1/2024	12/31/2999
H0031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health assessment, by non-physician	1/1/1950	12/31/2999
H0032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health service plan development by non-physician	1/1/1950	12/31/2999
H0038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Self-help/peer services, per 15 minutes	1/1/1950	12/31/2999
H0039	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assertive community treatment, face-to-face, per 15 minutes	1/1/1950	12/31/2999
H0040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assertive community treatment program, per diem	1/1/1950	12/31/2999
H0041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, child, non-therapeutic, per diem	1/1/1950	12/31/2999
H0042	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, child, non-therapeutic, per month	1/1/1950	12/31/2999
H0043	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported housing, per diem	1/1/1950	12/31/2999
H0044	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported housing, per month	1/1/1950	12/31/2999
H0045	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Respite care services, not in the home, per diem	1/1/1950	12/31/2999
H0046	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Mental health services, not otherwise specified	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
H0047	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alcohol and/or other drug abuse services, not otherwise specified	7/1/2008	12/31/2999
H0051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Traditional healing service	4/1/2024	12/31/2999
H1010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-medical family planning education, per session	1/1/1950	12/31/2999
H1011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Family assessment by licensed behavioral health professional for state defined purposes	1/1/1950	12/31/2999
H2000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive multidisciplinary evaluation	1/1/1950	12/31/2999
H2011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Crisis intervention service, per 15 minutes	1/1/1950	12/31/2999
H2012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Behavioral health day treatment, per hour	1/1/1950	12/31/2999
H2013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psychiatric health facility service, per diem	1/1/1950	12/31/2999
H2014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Skills training and development, per 15 minutes	1/1/1950	12/31/2999
H2015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive community support services, per 15 minutes	1/1/1950	12/31/2999
H2016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive community support services, per diem	1/1/1950	12/31/2999
H2021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community-based wrap-around services, per 15 minutes	1/1/1950	12/31/2999
H2022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community-based wrap-around services, per diem	1/1/1950	12/31/2999
H2023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported employment, per 15 minutes	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
H2024	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported employment, per diem	1/1/1950	12/31/2999
H2025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing support to maintain employment, per 15 minutes	1/1/1950	12/31/2999
H2026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing support to maintain employment, per diem	1/1/1950	12/31/2999
H2027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psychoeducational service, per 15 minutes	1/1/1950	12/31/2999
H2028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sexual offender treatment service, per 15 minutes	1/1/1950	12/31/2999
H2029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sexual offender treatment service, per diem	1/1/1950	12/31/2999
H2030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health clubhouse services, per 15 minutes	1/1/1950	12/31/2999
H2031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health clubhouse services, per diem	1/1/1950	12/31/2999
H2032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Activity therapy, per 15 minutes	1/1/1950	12/31/2999
H2033	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multisystemic therapy for juveniles, per 15 minutes	1/1/1950	12/31/2999
H2034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol and/or drug abuse halfway house services, per diem	1/1/1950	12/31/2999
H2037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Developmental delay prevention activities, dependent child of client, per 15 minutes	1/1/1950	12/31/2999
J0013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esketamine, nasal spray, 1 mg	1/1/2026	12/31/2999
J0174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lecanemab-irmb, 1 mg	7/6/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0175	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, donanemab-azbt, 2 mg	7/2/2024	12/31/2999
J0177	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept hd, 1 mg	4/1/2024	12/31/2999
J0178	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept, 1 mg	1/1/2013	12/31/2999
J0179	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, brolucizumab-dbll, 1 mg	8/15/2023	12/31/2999
J0217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, velmanase alfa-tycv, 1 mg	1/1/2024	12/31/2999
J0218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, olipudase alfa-rpcp, 1 mg	7/1/2023	12/31/2999
J0219	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, avalglucosidase alfa-ngpt, 4 mg	4/1/2022	12/31/2999
J0220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	7/1/2014	12/31/2999
J0220	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J0222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, Patisiran, 0.1 mg	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0223	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, givosiran, 0.5 mg	11/15/2020	12/31/2999
J0224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lumasiran, 0.5 mg	7/1/2021	12/31/2999
J0225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, vutrisiran, 1 mg	1/1/2023	12/31/2999
J0248	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, remdesivir, 1mg	5/1/2024	12/31/2999
J0256	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG	10/24/2019	12/31/2999
J0270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2014	12/31/2999
J0275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	11/1/2014	12/31/2999
J0470	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, dimercaprol, per 100 mg	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, belatacept, 1 mg	3/1/2024	12/31/2999
J0491	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, anifrolumab-fnia, 1 mg	4/1/2022	12/31/2999
J0517	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, benralizumab, 1 mg	1/1/2019	12/31/2999
J0585	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	1/1/1950	12/31/2999
J0586	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	1/1/2010	12/31/2999
J0589	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, daxibotulinumtoxina-lanm, 1 unit	4/1/2024	12/31/2999
J0775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	1/1/2011	12/31/2999
J0791	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, crizanlizumab-tmca, 5 mg	3/1/2021	12/31/2999
J0895	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, deferoxamine mesylate, 500 mg	10/15/2007	12/31/2999
J1071	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone cypionate, 1mg	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone cypionate (azmiro), 1 mg	4/1/2025	12/31/2999
J1073	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testosterone pellet, implant, 75 mg	1/1/2026	12/31/2999
J1203	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, cipaglucosidase alfa-atga, 5 mg	4/1/2024	12/31/2999
J1299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, eculizumab, 2 mg	4/1/2025	12/31/2999
J1301	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, edaravone, 1 mg	1/1/2019	12/31/2999
J1302	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sutimlimab-jome, 10 mg	10/1/2022	12/31/2999
J1303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ravulizumab-cwvz, 10 mg	7/15/2020	12/31/2999
J1304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tofersen, 1 mg	1/1/2024	12/31/2999
J1305	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, evinacumab-dgnb, 5mg	10/1/2021	12/31/2999
J1306	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, inclisiran, 1 mg	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1307	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, crovalimab-akkz, 10 mg	1/1/2025	12/31/2999
J1323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, elranatamab-bcmm, 1 mg	4/1/2024	12/31/2999
J1325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, epoprostenol, 0. 5 mg	7/27/2009	12/31/2999
J1411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	4/1/2023	12/31/2999
J1412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	1/1/2024	12/31/2999
J1413	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	1/1/2024	12/31/2999
J1426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, casimersen, 10 mg	10/1/2021	12/31/2999
J1427	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, viltolarsen, 10 mg	5/1/2021	12/31/2999
J1428	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, eteplirsen, 10 mg	1/1/2018	12/31/2999
J1429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, golodirsen, 10 mg	11/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1440	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fecal microbiota, live - jslm, 1 ml	7/1/2023	12/31/2999
J1551	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, immune globulin (cutaquig), 100 mg	7/1/2022	12/31/2999
J1552	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, immune globulin (alyglo), 500 mg	1/1/2025	12/31/2999
J1554	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, immune globulin (asceniv), 500 mg	4/1/2021	12/31/2999
J1566	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, immune globulin, intravenous, lyophilized (e. G. Powder), not otherwise specified, 500 mg	10/24/2019	12/31/2999
J1576	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	7/1/2023	12/31/2999
J1599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG	10/24/2019	12/31/2999
J1628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, guselkumab, 1 mg	1/1/2025	12/31/2999
J1726	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, (makena), 10 mg	7/15/2023	12/31/2999
J1729	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1729	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	7/15/2023	12/31/2999
J1747	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, spesolimab-sbzo, 1 mg	5/1/2023	12/31/2999
J1811	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units	7/1/2023	12/31/2999
J1812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin (fiasp), per 5 units	7/1/2023	12/31/2999
J1813	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units	7/1/2023	12/31/2999
J1814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin (lyumjev), per 5 units	7/1/2023	12/31/2999
J1823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, inebilizumab-cdon, 1 mg	3/1/2021	12/31/2999
J1930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, LANREOTIDE, 1 MG	3/1/2024	12/31/2999
J1932	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lanreotide, (cipla), 1 mg	10/1/2022	12/31/2999
J2267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, mirikizumab-mrkz, 1 mg	8/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J2351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	4/1/2025	12/31/2999
J2353	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, octreotide, depot form for intramuscular injection, 1 mg	3/1/2024	12/31/2999
J2354	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	3/1/2024	12/31/2999
J2356	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tezepelumab-ekko, 1 mg	7/1/2022	12/31/2999
J2440	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, papaverine hcl, up to 60 mg	2/15/2007	12/31/2999
J2508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegunigalsidase alfa-iwxj, 1 mg	1/1/2024	12/31/2999
J2777	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, faricimab-svoa, 0.1 mg	10/1/2022	12/31/2999
J2778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, RANIBIZUMAB, 0.1 MG	1/1/2008	12/31/2999
J2779	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	7/1/2022	12/31/2999
J2782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, avacincaptad pegol, 0.1 mg	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J2787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	9/1/2020	12/31/2999
J2802	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, romiplostim, 1 microgram	1/1/2025	12/31/2999
J3032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, eptinezumab-jjmr, 1 mg	11/15/2020	12/31/2999
J3055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, talquetamab-tgvs, 0.25 mg	4/1/2024	12/31/2999
J3111	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, romosozumab-aqqg, 1 mg	3/1/2024	12/31/2999
J3121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone enanthate, 1mg	10/1/2024	12/31/2999
J3145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone undecanoate, 1 mg	10/1/2024	12/31/2999
J3241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, teprotumumab-trbw, 10 mg	11/1/2020	12/31/2999
J3247	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, secukinumab, intravenous, 1 mg	8/15/2024	12/31/2999
J3299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, triamcinolone acetonide (xipere), 1 mg	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3387	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, elivaldogene autotemcel, per treatment	1/1/2026	12/31/2999
J3389	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Topical administration, prademagene zamikeracel, per treatment	1/1/2026	12/31/2999
J3392	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, exagamglogene autotemcel, per treatment	1/1/2025	12/31/2999
J3393	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, betibeglogene autotemcel, per treatment	7/1/2024	12/31/2999
J3394	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lovotibeglogene autotemcel, per treatment	7/1/2024	12/31/2999
J3396	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, VERTEPORFIN, 0.1 MG	1/1/2005	12/31/2999
J3398	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	1/1/2019	12/31/2999
J3399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	7/1/2020	12/31/2999
J3401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	1/1/2024	12/31/2999
J3403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revakinagene taroretcel-lwey, per implant	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3490	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drugs	1/1/1950	12/31/2999
J3570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laetrile, amygdalin, vitamin b17	6/1/2015	12/31/2999
J3590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified biologics	1/1/1950	12/31/2999
J3591	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drug or biological used for esrd on dialysis	1/1/2019	12/31/2999
J7183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	3/1/2024	12/31/2999
J7192	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U., NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J7195	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified	10/24/2019	12/31/2999
J7199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hemophilia clotting factor, not otherwise classified	1/1/1950	12/31/2999
J7213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, coagulation factor ix (recombinant), ixinity, 1 i.u.	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form (354 mg)	1/1/1950	12/31/2999
J7311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	6/15/2011	12/31/2999
J7313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	1/1/2016	12/31/2999
J7345	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	1/1/2018	12/31/2999
J7351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bimatoprost, intracameral implant, 1 microgram	10/1/2020	12/31/2999
J7355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, travoprost, intracameral implant, 1 microgram	7/1/2024	12/31/2999
J7356	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg	7/1/2025	12/31/2999
J7402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mometasone furoate sinus implant, (sinuva), 10 micrograms	5/15/2021	12/31/2999
J7599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Immunosuppressive drug, not otherwise classified	1/1/1950	12/31/2999
J7604	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7607	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	12/1/2020	12/31/2999
J7609	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	12/1/2020	12/31/2999
J7610	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	12/1/2020	12/31/2999
J7615	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	12/1/2020	12/31/2999
J7622	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7624	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7627	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	12/1/2020	12/31/2999
J7628	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7629	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7632	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	12/1/2020	12/31/2999
J7634	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	12/1/2020	12/31/2999
J7635	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7636	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7637	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7638	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7640	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	12/1/2020	12/31/2999
J7641	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	12/1/2020	12/31/2999
J7642	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7643	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7645	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7647	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7650	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7657	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7660	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7667	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	12/1/2020	12/31/2999
J7670	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	12/1/2020	12/31/2999
J7676	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	12/1/2020	12/31/2999
J7680	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7681	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7683	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7684	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	12/1/2020	12/31/2999
J7685	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	12/1/2020	12/31/2999
J7699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, inhalation solution administered through dme	1/1/1950	12/31/2999
J7799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, other than inhalation drugs, administered through dme	1/1/1950	12/31/2999
J7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compounded drug, not otherwise classified	1/1/2016	12/31/2999
J8498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, RECTAL/SUPPOSITORY, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, non chemotherapeutic, nos	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J8597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, chemotherapeutic, nos	1/1/1950	12/31/2999
J9011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, datopotamab deruxtecan-dlnk, 1 mg	10/1/2025	12/31/2999
J9024	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	4/1/2025	12/31/2999
J9029	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	7/1/2023	12/31/2999
J9038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, axatilimab-csfr, 0.1 mg	4/1/2025	12/31/2999
J9054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bortezomib (boruzu), 0.1 mg	4/1/2025	12/31/2999
J9056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bendamustine hydrochloride (vivimusta), 1 mg	7/1/2023	12/31/2999
J9057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, copanlisib, 1 mg	4/1/2024	12/31/2999
J9063	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, mirvetuximab soravtansine-gynx, 1 mg	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denileukin diftitox-cxdl, 1 mcg	4/1/2025	12/31/2999
J9174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, docetaxel (beizray), 1 mg	7/1/2025	12/31/2999
J9184	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, gemcitabine hydrochloride (avyxa), 200 mg	1/1/2026	12/31/2999
J9256	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, nipocalimab-aahu, 3 mg	1/1/2026	12/31/2999
J9274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tebentafusp-tebn, 1 microgram	10/1/2022	12/31/2999
J9282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mitomycin, intravesical instillation, 1 mg	1/1/2026	12/31/2999
J9285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, olaratumab, 10 mg	9/1/2019	12/31/2999
J9286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, glofitamab-gxbm, 2.5 mg	1/1/2024	12/31/2999
J9313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	4/1/2024	12/31/2999
J9321	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, epcoritamab-bysp, 0.16 mg	1/1/2024	12/31/2999
J9326	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, telisotuzumab vedotin-tllv, 1 mg	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sirolimus protein-bound particles, 1 mg	7/1/2022	12/31/2999
J9332	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, efgartigimod alfa-fcab, 2mg	7/1/2022	12/31/2999
J9333	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, rozanolixizumab-noli, 1 mg	1/1/2024	12/31/2999
J9334	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	1/1/2024	12/31/2999
J9341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, thiotepa (tepylute), 1 mg	7/1/2025	12/31/2999
J9342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, thiotepa, not otherwise specified, 1 mg	7/1/2025	12/31/2999
J9347	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tremelimumab-actl, 1 mg	7/1/2023	12/31/2999
J9350	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, mosunetuzumab-axgb, 1 mg	7/1/2023	12/31/2999
J9376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pozelimab-bbfg, 1 mg	4/1/2024	12/31/2999
J9380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, teclistamab-cqyv, 0.5 mg	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9381	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, teplizumab-mzwv, 5 mcg	7/1/2023	12/31/2999
J9600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, PORFIMER SODIUM, 75 MG	9/15/2008	12/31/2999
J9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, antineoplastic drugs	1/1/1950	12/31/2999
K0002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard hemi (low seat) wheelchair	3/15/2014	12/31/2999
K0003	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair	12/1/2011	12/31/2999
K0004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength, lightweight wheelchair	12/1/2011	12/31/2999
K0005	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultralightweight wheelchair	12/1/2011	12/31/2999
K0006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair	9/15/2006	12/31/2999
K0007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extra heavy duty wheelchair	9/15/2006	12/31/2999
K0008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom Manual Wheelchair/Base	4/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Other manual wheelchair/base	9/15/2006	12/31/2999
K0010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair	9/15/2006	12/31/2999
K0011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	7/27/2009	12/31/2999
K0012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight portable motorized/power wheelchair	7/27/2009	12/31/2999
K0013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom Motorized/Power Wheelchair Base	4/15/2016	12/31/2999
K0014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Other motorized/power wheelchair base	7/27/2009	12/31/2999
K0053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elevating footrests, articulating (telescoping), each	9/15/2006	12/31/2999
K0056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat height less than 17 or equal to or greater than 21 for a high strength, lightweight, or ultralightweight wheelchair	9/15/2006	12/31/2999
K0065	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Spoke protectors, each	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair component or accessory, not otherwise specified	9/15/2006	12/31/2999
K0108	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Wheelchair component or accessory, not otherwise specified	2/9/2017	12/31/2999
K0455	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infusion pump used for uninterrupted parenteral administration of medication, (e. G. , epoprostenol or treprostinol)	7/27/2009	12/31/2999
K0606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	10/29/2025	12/31/2999
K0669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat/back custom; no dme pdac ver	9/15/2006	12/31/2999
K0743	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS	8/1/2011	12/31/2999
K0744	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS	8/1/2011	12/31/2999
K0745	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	8/1/2011	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0746	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	8/1/2011	12/31/2999
K0800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0801	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0802	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0806	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0807	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0812	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	2/9/2017	12/31/2999
K0813	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0815	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0827	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0829	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999
K0830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0831	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999
K0841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0849	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0850	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0851	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0852	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0853	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0854	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0855	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999
K0856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0857	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0861	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0862	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0863	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0864	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	7/27/2009	12/31/2999
K0868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0869	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0870	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0871	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	7/27/2009	12/31/2999
K0877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0884	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0885	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	7/27/2009	12/31/2999
K0886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	7/27/2009	12/31/2999
K0890	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	7/27/2009	12/31/2999
K0891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	7/27/2009	12/31/2999
K0898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	10/1/2006	12/31/2999
K0899	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power mobile device; no dme pdac	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K1004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low frequency ultrasonic diathermy treatment device for home use	12/1/2020	12/31/2999
K1007	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	3/1/2021	12/31/2999
K1027	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	10/1/2021	12/31/2999
K1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	4/1/2022	12/31/2999
K1034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Provision of COVID-19 test, nonprescription self-administered and self-collected use, FDA approved, authorized or cleared, one test count	5/12/2023	12/31/2999
K1035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Molecular diagnostic test reader, nonprescription self-administered and self-collected use, fda approved, authorized or cleared	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K1036	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month	10/1/2023	12/31/2999
K1037	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	10/1/2024	12/31/2999
L0120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar)	11/1/2015	12/31/2999
L0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Addition to spinal orthosis, not otherwise specified	10/24/2019	12/31/2999
L1499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Spinal orthosis, not otherwise specified	1/1/1950	12/31/2999
L1834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, without knee joint, rigid, custom-fabricated	10/1/2008	12/31/2999
L1840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated	1/1/1950	12/31/2999
L1844	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L1846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/1950	12/31/2999
L1860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, modification of supracondylar prosthetic socket, custom-fabricated (sk)	10/1/2008	12/31/2999
L2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity orthoses, not otherwise specified	1/1/1950	12/31/2999
L3001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, spenco, each	5/15/2007	12/31/2999
L3002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, plastazote or equal, each	5/15/2007	12/31/2999
L3003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, silicone gel, each	5/15/2007	12/31/2999
L3010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, longitudinal arch support, each	5/15/2007	12/31/2999
L3020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each	5/15/2007	12/31/2999
L3030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, formed to patient foot, each	5/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each	3/1/2009	12/31/2999
L3040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal, each	5/15/2007	12/31/2999
L3050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, metatarsal, each	5/15/2007	12/31/2999
L3060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	5/15/2007	12/31/2999
L3070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, longitudinal, each	5/15/2007	12/31/2999
L3080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, metatarsal, each	5/15/2007	12/31/2999
L3090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each	5/15/2007	12/31/2999
L3100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hallus-valgus night dynamic splint, prefabricated, off-the-shelf	1/1/2006	12/31/2999
L3140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, abduction rotation bar, including shoes	1/1/2006	12/31/2999
L3150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, abduction rotatation bar, without shoes	1/1/2006	12/31/2999
L3160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, adjustable shoe-styled positioning device	1/1/2006	12/31/2999
L3170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, plastic, silicone or equal, heel stabilizer, prafabricated, off-the-shelf, each	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3201	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, infant	1/1/2006	12/31/2999
L3202	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, child	1/1/2006	12/31/2999
L3203	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, junior	1/1/2006	12/31/2999
L3204	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, infant	1/1/2006	12/31/2999
L3206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, child	1/1/2006	12/31/2999
L3207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, junior	1/1/2006	12/31/2999
L3212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, infant	1/1/2006	12/31/2999
L3213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, child	1/1/2006	12/31/2999
L3214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, junior	1/1/2006	12/31/2999
L3215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH	1/1/2006	12/31/2999
L3216	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH	1/1/2006	12/31/2999
L3217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	1/1/2006	12/31/2999
L3219	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH	1/1/2006	12/31/2999
L3221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH	1/1/2006	12/31/2999
L3222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3224	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)	1/1/2006	12/31/2999
L3225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)	1/1/2006	12/31/2999
L3230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH	1/1/2006	12/31/2999
L3250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	1/1/2006	12/31/2999
L3251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, shoe molded to patient model, silicone shoe, each	1/1/2006	12/31/2999
L3252	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each	1/1/2006	12/31/2999
L3253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, molded shoe plastazote (or similar) custom fitted, each	1/1/2006	12/31/2999
L3254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-standard size or width	1/1/2006	12/31/2999
L3255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-standard size or length	1/1/2006	12/31/2999
L3257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, additional charge for split size	1/1/2006	12/31/2999
L3265	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Plastazote sandal, each	1/1/2006	12/31/2999
L3300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel, tapered to metatarsals, per inch	1/1/2006	12/31/2999
L3310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel and sole, neoprene, per inch	1/1/2006	12/31/2999
L3320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel and sole, cork, per inch	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, metal extension (skate)	1/1/2006	12/31/2999
L3332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, inside shoe, tapered, up to one-half inch	1/1/2006	12/31/2999
L3334	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel, per inch	1/1/2006	12/31/2999
L3340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel wedge, sach	1/1/2006	12/31/2999
L3350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel wedge	1/1/2006	12/31/2999
L3360	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sole wedge, outside sole	1/1/2006	12/31/2999
L3370	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sole wedge, between sole	1/1/2006	12/31/2999
L3380	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clubfoot wedge	1/1/2006	12/31/2999
L3390	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Outflare wedge	1/1/2006	12/31/2999
L3400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Metatarsal bar wedge, rocker	1/1/2006	12/31/2999
L3410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Metatarsal bar wedge, between sole	1/1/2006	12/31/2999
L3420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Full sole and heel wedge, between sole	1/1/2006	12/31/2999
L3430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, counter, plastic reinforced	1/1/2006	12/31/2999
L3440	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, counter, leather reinforced	1/1/2006	12/31/2999
L3450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, sach cushion type	1/1/2006	12/31/2999
L3455	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, new leather, standard	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3460	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, new rubber, standard	1/1/2006	12/31/2999
L3465	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, thomas with wedge	1/1/2006	12/31/2999
L3470	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, thomas extended to ball	1/1/2006	12/31/2999
L3480	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, pad and depression for spur	1/1/2006	12/31/2999
L3485	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, pad, removable for spur	1/1/2006	12/31/2999
L3500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, leather	1/1/2006	12/31/2999
L3510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, rubber	1/1/2006	12/31/2999
L3520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, felt covered with leather	1/1/2006	12/31/2999
L3530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, sole, half	1/1/2006	12/31/2999
L3540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, sole, full	1/1/2006	12/31/2999
L3550	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, toe tap standard	1/1/2006	12/31/2999
L3560	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, toe tap, horseshoe	1/1/2006	12/31/2999
L3570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, special extension to instep (leather with eyelets)	1/1/2006	12/31/2999
L3580	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, convert instep to velcro closure	1/1/2006	12/31/2999
L3590	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, convert firm shoe counter to soft counter	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3595	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, march bar	1/1/2006	12/31/2999
L3600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, caliper plate, existing	1/1/2006	12/31/2999
L3610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, caliper plate, new	1/1/2006	12/31/2999
L3620	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, solid stirrup, existing	1/1/2006	12/31/2999
L3630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, solid stirrup, new	1/1/2006	12/31/2999
L3640	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, dennis browne splint (riveton), both shoes	1/1/2006	12/31/2999
L3649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Orthopedic shoe, modification, addition or transfer, not otherwise specified	1/1/1950	12/31/2999
L3649	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, modification, addition or transfer, not otherwise specified	1/1/2006	12/31/2999
L3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper limb orthosis, not otherwise specified	1/1/1950	12/31/2999
L5610	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee, hydracadence system	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control	7/1/2007	12/31/2999
L5613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control	7/1/2007	12/31/2999
L5614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control	7/1/2007	12/31/2999
L5615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	1/1/2024	12/31/2999
L5616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control	7/1/2007	12/31/2999
L5629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, acrylic socket	7/1/2007	12/31/2999
L5631	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	7/1/2007	12/31/2999
L5638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, leather socket	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, wood socket	7/1/2007	12/31/2999
L5640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, knee disarticulation, leather socket	7/1/2007	12/31/2999
L5642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, leather socket	7/1/2007	12/31/2999
L5644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, wood socket	7/1/2007	12/31/2999
L5645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, flexible inner socket, external frame	7/1/2007	12/31/2999
L5646	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	7/1/2007	12/31/2999
L5647	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee suction socket	7/1/2007	12/31/2999
L5648	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	7/1/2007	12/31/2999
L5651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, flexible inner socket, external frame	7/1/2007	12/31/2999
L5652	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, manual/automated adjustable air, fluid, gel or equal socket insert for limb volume management, any materials	10/1/2025	12/31/2999
L5670	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar)	7/1/2007	12/31/2999
L5676	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Additions to lower extremity, below knee, knee joints, single axis, pair	7/1/2007	12/31/2999
L5704	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, below knee	7/1/2007	12/31/2999
L5705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, above knee	7/1/2007	12/31/2999
L5706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, knee disarticulation	7/1/2007	12/31/2999
L5710	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, manual lock	7/1/2007	12/31/2999
L5711	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material	7/1/2007	12/31/2999
L5712	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	7/1/2007	12/31/2999
L5716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	7/1/2007	12/31/2999
L5718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	7/1/2007	12/31/2999
L5722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	7/1/2007	12/31/2999
L5724	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	7/1/2007	12/31/2999
L5726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	7/1/2007	12/31/2999
L5728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	7/1/2007	12/31/2999
L5780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	7/1/2007	12/31/2999
L5785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	7/1/2007	12/31/2999
L5790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5795	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	7/1/2007	12/31/2999
L5810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, manual lock	7/1/2007	12/31/2999
L5811	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	7/1/2007	12/31/2999
L5812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	7/1/2007	12/31/2999
L5814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	7/1/2007	12/31/2999
L5816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	7/1/2007	12/31/2999
L5818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	7/1/2007	12/31/2999
L5822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	7/1/2007	12/31/2999
L5824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	7/1/2007	12/31/2999
L5827	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping	4/1/2025	12/31/2999
L5828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	7/1/2007	12/31/2999
L5830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control	7/1/2007	12/31/2999
L5840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	7/1/2007	12/31/2999
L5841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	4/1/2024	12/31/2999
L5848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	7/1/2007	12/31/2999
L5856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	5/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5857	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	9/1/2020	12/31/2999
L5858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	5/15/2007	12/31/2999
L5859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	1/1/2013	12/31/2999
L5926	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	1/1/2024	12/31/2999
L5961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	9/24/2012	12/31/2999
L5962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5964	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	7/1/2007	12/31/2999
L5966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	7/1/2007	12/31/2999
L5968	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	4/15/2015	12/31/2999
L5969	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	1/1/2014	12/31/2999
L5970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, external keel, sach foot	7/1/2007	12/31/2999
L5972	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, flexible keel	7/1/2007	12/31/2999
L5973	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	11/15/2019	12/31/2999
L5974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, single axis ankle/foot	7/1/2007	12/31/2999
L5976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)	7/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5978	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, multiaxial ankle/foot	7/1/2007	12/31/2999
L5979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system	7/1/2007	12/31/2999
L5980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, flex foot system	7/1/2007	12/31/2999
L5981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, flex-walk system or equal	7/1/2007	12/31/2999
L5982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All exoskeletal lower extremity prostheses, axial rotation unit	7/1/2007	12/31/2999
L5984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	7/1/2007	12/31/2999
L5985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	7/1/2007	12/31/2999
L5986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	7/1/2007	12/31/2999
L5987	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis, shank foot system with vertical loading pylon	7/1/2007	12/31/2999
L5991	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	10/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L6026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	1/1/2015	12/31/2999
L6028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Partial hand, finger, and thumb prosthesis without prosthetic digit(s)/thumb, amputation at metacarpal level, including flexible or non-flexible interface, molded to patient model, including palm, for use without external power and/or passive prosthetic digit/thumb, not including inserts described by l6692	4/1/2025	12/31/2999
L6029	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, test socket/interface, partial hand including fingers	4/1/2025	12/31/2999
L6030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, external frame, partial hand including fingers	4/1/2025	12/31/2999
L6031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to upper extremity prosthesis, partial hand including fingers, ultralight material (titanium, carbon fiber or equal)	4/1/2025	12/31/2999
L6033	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to upper extremity prosthesis, partial hand including fingers, acrylic material	4/1/2025	12/31/2999
L6034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Partial hand, finger, and thumb prosthesis without prosthetic digit(s)/thumb, amputation at distal to metacarpal joint, including flexible or non-flexible interface, molded to patient model, for use without external power and/or passive prosthetic digit/thumb, not including inserts described by l6692	10/1/2025	12/31/2999
L6035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Single prosthetic digit, mechanical, can include metacarpophalangeal (mcp), proximal interphalangeal (pip), and/or distal interphalangeal (dip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement	10/1/2025	12/31/2999
L6036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prosthetic thumb, mechanical, can include metacarpophalangeal (mcp), interphalangeal (ip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2025	12/31/2999
L6038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to single prosthetic digit or thumb, mechanical, attachment, multiaxial and/or internal/external rotation/abduction/adduction mechanism, with or without locking feature, any material	10/1/2025	12/31/2999
L6039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Passive prosthetic digit or thumb prosthesis not including hand restoration partial hand, full or partial, custom made, any material, initial or replacement, per single passive prosthetic digit or thumb	10/1/2025	12/31/2999
L6611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	4/1/2009	12/31/2999
L6621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE	4/1/2009	12/31/2999
L6700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT	9/1/2020	12/31/2999
L6880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	1/1/2012	12/31/2999
L6882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control feature, addition to upper limb prosthetic terminal device	4/1/2009	12/31/2999
L6920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6925	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6945	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L6970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	4/1/2009	12/31/2999
L7007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	4/1/2009	12/31/2999
L7008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	4/1/2009	12/31/2999
L7009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	4/1/2009	12/31/2999
L7040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PREHENSILE ACTUATOR, SWITCH CONTROLLED	4/1/2009	12/31/2999
L7045	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	4/1/2009	12/31/2999
L7170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, hosmer or equal, switch controlled	4/1/2009	12/31/2999
L7180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, microprocessor sequential control of elbow and terminal device	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7181	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	4/1/2009	12/31/2999
L7185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, adolescent, variety village or equal, switch controlled	4/1/2009	12/31/2999
L7186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, child, variety village or equal, switch controlled	4/1/2009	12/31/2999
L7190	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	4/1/2009	12/31/2999
L7191	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, child, variety village or equal, myoelectronically controlled	4/1/2009	12/31/2999
L7259	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic wrist rotator, any type	1/1/2015	12/31/2999
L7360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Six volt battery, each	4/1/2009	12/31/2999
L7362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger, six volt, each	4/1/2009	12/31/2999
L7364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Twelve volt battery, each	4/1/2009	12/31/2999
L7366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger, twelve volt, each	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lithium ion battery, rechargeable, replacement	4/1/2009	12/31/2999
L7368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	7/15/2007	12/31/2999
L7406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to upper extremity prosthesis, user adjustable, mechanical, residual limb volume management system (with or without lamination kit)	4/1/2025	12/31/2999
L7499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L7900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Male vacuum erection system	6/1/2008	12/31/2999
L7902	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tension ring, for vacuum erection device, any type, replacement only, each	7/1/2022	12/31/2999
L8039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Breast prosthesis, not otherwise specified	10/24/2019	12/31/2999
L8048	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unspecified maxillofacial prosthesis, by report, provided by a non-physician	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure for miscellaneous prosthetic services	1/1/1950	12/31/2999
L8603	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	5/15/2024	12/31/2999
L8605	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	12/1/2020	12/31/2999
L8606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	1/1/1950	12/31/2999
L8607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	1/1/2016	12/31/2999
L8609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ARTIFICIAL CORNEA	1/1/2015	12/31/2999
L8612	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt	7/1/2014	12/31/2999
L8678	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	4/1/2023	12/31/2999
L8679	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator, pulse generator, any type	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8680	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator electrode, each	1/1/2006	12/31/2999
L8681	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY	1/1/2006	12/31/2999
L8682	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator radiofrequency receiver	1/1/2006	12/31/2999
L8683	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	7/15/2023	12/31/2999
L8685	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	7/15/2023	12/31/2999
L8686	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	7/15/2023	12/31/2999
L8687	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	7/15/2023	12/31/2999
L8688	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	7/15/2023	12/31/2999
L8689	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8694	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Auditory osseointegrated device, transducer/actuator, replacement only, each	1/1/2018	12/31/2999
L8695	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	1/1/2007	12/31/2999
L8698	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Miscellaneous component, supply or accessory for use with total artificial heart system	1/1/2019	12/31/2999
L8699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic implant, not otherwise specified	1/1/1950	12/31/2999
L8701	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2019	12/31/2999
L8702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg	10/1/2024	12/31/2999
L8721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receptor sole for use with l8720, replacement, each	10/1/2024	12/31/2999
M0001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advancing cancer care mips value pathways	1/1/2023	12/31/2999
M0002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Optimal care for kidney health mips value pathways	1/1/2023	12/31/2999
M0004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Quality care for patients with neurological conditions mips value pathway	1/1/2023	12/31/2999
M0005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Value in primary care mips value pathway	1/1/2023	12/31/2999
M0075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cellular therapy	1/1/1950	12/31/2999
M0076	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Prolotherapy	1/1/2023	12/31/2999
M0100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intragastric hypothermia using gastric freezing	1/1/1950	12/31/2999
M0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Iv chelation therapy (chemical endarterectomy)	1/1/1950	12/31/2999
M1150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a history of heart transplant or with a left ventricular assist device (lvad)	1/1/2023	12/31/2999
M1152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a history of heart transplant or with a left ventricular assist device (lvad)	1/1/2023	12/31/2999
M1153	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with diagnosis of osteoporosis on date of encounter	1/1/2023	12/31/2999
M1159	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2023	12/31/2999
M1160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the meningococcal vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1161	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1163	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the hpv vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1164	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with dementia any time during the patient's history through the end of the measurement period	1/1/2023	12/31/2999
M1165	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1166	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report for tissue specimens produced from wide local excisions or re-excisions	1/1/2023	12/31/2999
M1167	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In hospice or using hospice services during the measurement period	1/1/2023	12/31/2999
M1168	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1169	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine)	1/1/2023	12/31/2999
M1170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1171	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1172	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999
M1173	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1174	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received at least two doses of the herpes zoster recombinant vaccine (at least 28 days apart) on october 20, 2017, through the end of the measurement period	1/1/2023	12/31/2999
M1175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)	1/1/2023	12/31/2999
M1176	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive two doses of the herpes zoster recombinant vaccine (at least 28 days apart) on october 20, 2017, through the end of the measurement period	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1177	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2023	12/31/2999
M1178	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)	1/1/2023	12/31/2999
M1179	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 19th birthday and before or during measurement period	1/1/2023	12/31/2999
M1180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients on immune checkpoint inhibitor therapy	1/1/2023	12/31/2999
M1181	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Grade 2 or above diarrhea and/or grade 2 or above colitis	1/1/2023	12/31/2999
M1182	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not eligible due to pre-existing inflammatory bowel disease (ibd) (e.g., ulcerative colitis, crohn's disease)	1/1/2023	12/31/2999
M1183	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1184	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999
M1185	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of immune checkpoint inhibitor therapy not held and/or corticosteroids or immunosuppressants prescribed or administered was not performed, reason not given	1/1/2023	12/31/2999
M1186	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who have an order for or are receiving hospice or palliative care	1/1/2023	12/31/2999
M1187	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of end stage renal disease (esrd)	1/1/2023	12/31/2999
M1188	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of chronic kidney disease (ckd) stage 5	1/1/2023	12/31/2999
M1189	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a kidney health evaluation defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) performed	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a kidney health evaluation was not performed or defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr)	1/1/2023	12/31/2999
M1191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2023	12/31/2999
M1192	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with an existing diagnosis of squamous cell carcinoma of the esophagus	1/1/2023	12/31/2999
M1193	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1194	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1195	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1196	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	1/1/2023	12/31/2999
M1197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	1/1/2023	12/31/2999
M1198	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients receiving rrt	1/1/2023	12/31/2999
M1200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ace inhibitor (ace-i) or arb therapy prescribed during the measurement period	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1201	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2023	12/31/2999
M1202	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing ace inhibitor or arb therapy during the measurement period, (e.g., patient declined, other patient reasons)	1/1/2023	12/31/2999
M1203	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ace inhibitor or arb therapy not prescribed during the measurement period, reason not given	1/1/2023	12/31/2999
M1204	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	1/1/2023	12/31/2999
M1205	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2023	12/31/2999
M1207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	1/1/2023	12/31/2999
M1208	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	1/1/2023	12/31/2999
M1209	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class, (table 4), without appropriate diagnoses	1/1/2023	12/31/2999
M1210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class, (table 4), not ordered	1/1/2023	12/31/2999
M1211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent glycemic status assessment (hba1c or gmi) level > 9.0%	1/1/2024	12/31/2999
M1212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glycemic status assessment (hba1c or gmi) level is missing, or was not performed during the measurement period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No history of spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) and present spirometry is >= 70%	1/1/2024	12/31/2999
M1214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and reviewed	1/1/2024	12/31/2999
M1215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not documenting and reviewing spirometry results (e.g., patients with dementia or tracheostomy)	1/1/2024	12/31/2999
M1216	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed with results documented during the encounter	1/1/2024	12/31/2999
M1217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of system reason(s) for not documenting and reviewing spirometry results (e.g., spirometry equipment not available at the time of the encounter)	1/1/2024	12/31/2999
M1218	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has copd symptoms (e.g., dyspnea, cough/sputum, wheezing)	1/1/2024	12/31/2999
M1220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; with evidence of retinopathy	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; without evidence of retinopathy	1/1/2024	12/31/2999
M1222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glaucoma plan of care not documented, reason not otherwise specified	1/1/2024	12/31/2999
M1223	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glaucoma plan of care documented	1/1/2024	12/31/2999
M1224	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraocular pressure (iop) reduced by a value less than 20% from the pre-intervention level	1/1/2024	12/31/2999
M1225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraocular pressure (iop) reduced by a value of greater than or equal to 20% from the pre-intervention level	1/1/2024	12/31/2999
M1226	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iop measurement not documented, reason not otherwise specified	1/1/2024	12/31/2999
M1227	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evidence-based therapy was prescribed	1/1/2024	12/31/2999
M1228	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1229	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1231	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receives hcv antibody test with nonreactive result	1/1/2024	12/31/2999
M1232	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receives hcv antibody test with reactive result	1/1/2024	12/31/2999
M1233	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient does not receive hcv antibody test or patient does receive hcv antibody test but results not documented, reason not given	1/1/2024	12/31/2999
M1234	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia	1/1/2024	12/31/2999
M1235	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1236	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Baseline mrs > 2	1/1/2024	12/31/2999
M1237	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1238	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1239	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt this provider and team understood what is important to me in my life	1/1/2024	12/31/2999
M1243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient provided a response other than completely true for the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1248	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded completely true for the question of patient felt this provider and team understood what is important to me in my life	1/1/2024	12/31/2999
M1250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded as completely true for the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients for whom a proxy completed the entire hu survey on their behalf for any reason (no patient involvement)	1/1/2024	12/31/2999
M1252	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were deceased when the hu survey reached them	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1256	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prior history of known cvd	1/1/2024	12/31/2999
M1257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cvd risk assessment not performed or incomplete (e.g., cvd risk assessment was not documented), reason not otherwise specified	1/1/2024	12/31/2999
M1258	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cvd risk assessment performed, have a documented calculated risk score	1/1/2024	12/31/2999
M1259	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient status documented within the first year of initiating dialysis	1/1/2024	12/31/2999
M1260	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient status not documented within the first year of initiating dialysis	1/1/2024	12/31/2999
M1261	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients that were on the kidney or kidney-pancreas waitlist prior to initiation of dialysis	1/1/2024	12/31/2999
M1262	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a transplant prior to initiation of dialysis	1/1/2024	12/31/2999
M1263	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients in hospice on their initiation of dialysis date or during the month of evaluation	1/1/2024	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were admitted to a skilled nursing facility (snf) during the month of evaluation were excluded from that month	1/1/2024	12/31/2999
M1275	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients determined to be in hospice were excluded from month of evaluation and the remainder of reporting period	1/1/2024	12/31/2999
M1276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	1/1/2024	12/31/2999
M1277	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Colorectal cancer screening results documented and reviewed	1/1/2024	12/31/2999
M1278	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented	1/1/2024	12/31/2999
M1279	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given	1/1/2024	12/31/2999
M1280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure reading not documented, reason not given	1/1/2024	12/31/2999
M1282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco non-user	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco user	1/1/2024	12/31/2999
M1284	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	1/1/2024	12/31/2999
M1286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason	1/1/2024	12/31/2999
M1287	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented below normal parameters and a follow-up plan is documented	1/1/2024	12/31/2999
M1288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented reason for not screening or recommending a follow-up for high blood pressure	1/1/2024	12/31/2999
M1289	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1290	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not eligible due to active diagnosis of hypertension	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1291	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1292	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented above normal parameters and a follow-up plan is documented	1/1/2024	12/31/2999
M1294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Normal blood pressure reading documented, follow-up not required	1/1/2024	12/31/2999
M1295	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis or past history of total colectomy or colorectal cancer	1/1/2024	12/31/2999
M1296	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented within normal parameters and no follow-up plan is required	1/1/2024	12/31/2999
M1297	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented due to medical reason or patient refusal of height or weight measurement	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1298	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter	1/1/2024	12/31/2999
M1299	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza immunization administered or previously received	1/1/2024	12/31/2999
M1300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1302	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	1/1/2024	12/31/2999
M1303	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2024	12/31/2999
M1304	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1305	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2024	12/31/2999
M1306	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period	1/1/2024	12/31/2999
M1307	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating the patient has received or is currently receiving palliative or hospice care	1/1/2024	12/31/2999
M1308	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza immunization was not administered, reason not given	1/1/2024	12/31/2999
M1309	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Palliative care services provided to patient any time during the measurement period	1/1/2024	12/31/2999
M1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anaphylaxis due to the vaccine on or before the date of the encounter	1/1/2024	12/31/2999
M1312	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for tobacco use	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period	1/1/2024	12/31/2999
M1314	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented and no reason is given	1/1/2024	12/31/2999
M1315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified	1/1/2024	12/31/2999
M1316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current tobacco non-user	1/1/2024	12/31/2999
M1317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are counseled on connection with a csp and explicitly opt out	1/1/2024	12/31/2999
M1318	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1319	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening	1/1/2024	12/31/2999
M1320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who screened positive for at least 1 of the 5 hrsns	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1323	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1324	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1325	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2024	12/31/2999
M1326	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of hypotony	1/1/2024	12/31/2999
M1327	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 8 weeks	1/1/2024	12/31/2999
M1328	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of acute vitreous hemorrhage	1/1/2024	12/31/2999
M1329	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)	1/1/2024	12/31/2999
M1331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks from initial exam	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 2 weeks	1/1/2024	12/31/2999
M1333	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acute vitreous hemorrhage	1/1/2024	12/31/2999
M1334	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)	1/1/2024	12/31/2999
M1336	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks	1/1/2024	12/31/2999
M1337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acute pvd	1/1/2024	12/31/2999
M1338	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1339	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Index assessment completed using the 12-item whodas 2.0 or sds during the denominator identification period	1/1/2024	12/31/2999
M1341	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died during the performance period	1/1/2024	12/31/2999
M1343	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a baseline pam score and/or a second score within 4 to 12 months of baseline pam score	1/1/2024	12/31/2999
M1345	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a baseline pam score and a second score within 4 to 12 month of baseline pam score	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a net increase in pam score of at least 6 points within a 4 to 12 month period	1/1/2024	12/31/2999
M1347	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who achieved a net increase in pam score of at least 3 points in a 4 to 12 month period (passing)	1/1/2024	12/31/2999
M1348	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who achieved a net increase in pam score of at least 6-points in a 4 to 12 month period (excellent)	1/1/2024	12/31/2999
M1349	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a net increase in pam score of at least 3 points within a 4 to 12 month period	1/1/2024	12/31/2999
M1350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicidal ideation and/or behavior symptoms based on the c-ssrs or equivalent assessment	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/2024	12/31/2999
M1355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicide risk based on their clinician's evaluation or a clinician-rated tool	1/1/2024	12/31/2999
M1356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died during the measurement period	1/1/2024	12/31/2999
M1357	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment	1/1/2024	12/31/2999
M1358	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment	1/1/2024	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1368	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prevention and treatment of infectious disorders including hepatitis c and hiv mips value pathway	1/1/2024	12/31/2999
M1369	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Quality care in mental health and substance use disorders mips value pathway	1/1/2024	12/31/2999
M1370	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rehabilitative support for musculoskeletal care mips value pathway	1/1/2024	12/31/2999
P2031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hair analysis (excluding arsenic)	9/24/2012	12/31/2999
P9020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Platelet rich plasma, each unit	12/1/2020	12/31/2999
P9099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Blood component or product not otherwise classified	1/1/2020	12/31/2999
Q0035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cardiokymography	1/1/1950	12/31/2999
Q0114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fern test	1/1/1950	12/31/2999
Q0115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Post-coital direct, qualitative examinations of vaginal or cervical mucous	1/1/1950	12/31/2999
Q0477	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type	1/1/2011	12/31/2999
Q0479	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power module for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2011	12/31/2999
Q0480	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Driver for use with pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0481	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control unit for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor/display module for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0484	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor control cable for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0486	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0487	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0488	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power pack base for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0489	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power pack base for use with electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0490	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power source for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0491	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power supply cable for use with electric ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0494	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0495	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0496	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0497	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0498	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0501	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0502	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mobility cart for pneumatic ventricular assist device, replacement only	7/27/2009	12/31/2999
Q0503	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery for pneumatic ventricular assist device, replacement only, each	7/27/2009	12/31/2999
Q0504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2010	12/31/2999
Q0507	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0508	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0509	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	4/1/2013	12/31/2999
Q0511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	11/1/2024	12/31/2999
Q0521	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, RADIESSE, 0.1 ML	9/24/2012	12/31/2999
Q2028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sculptra, 0.5 mg	1/1/2014	12/31/2999
Q2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Influenza virus vaccine, not otherwise specified	10/24/2019	12/31/2999
Q2041	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	4/1/2018	12/31/2999
Q2049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	4/1/2024	12/31/2999
Q2050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg	10/24/2019	12/31/2999
Q2052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	4/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	4/1/2021	12/31/2999
Q2054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	10/1/2021	12/31/2999
Q2055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2022	12/31/2999
Q2056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/1/2022	12/31/2999
Q2057	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Cast supplies, for unlisted types and materials of casts	1/1/1950	12/31/2999
Q4051	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	1/1/1950	12/31/2999
Q4082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	1/1/2007	12/31/2999
Q4082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	1/1/2007	12/31/2999
Q4101	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Apligraf, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oasis wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4103	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oasis burn matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4104	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Integra bilayer matrix wound dressing (bmwd), per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Graftjacket, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra matrix, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4110	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Primatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4111	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gammagraft, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CYMETRA, INJECTABLE, 1CC	5/15/2021	12/31/2999
Q4113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GRAFTJACKET XPRESS, INJECTABLE, 1CC	5/15/2021	12/31/2999
Q4114	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	2/1/2021	12/31/2999
Q4115	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4116	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alloderm, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hyalomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4118	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MATRISTEM MICROMATRIX, 1 MG	5/15/2021	12/31/2999
Q4121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Theraskin, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermacell, dermacell awm or dermacell awm porous, per square centimeter (add-on, list separately in addition to primary procedure)	10/15/2021	12/31/2999
Q4123	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin rt, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4124	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oasis ultra tri-layer wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4125	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroflex, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4126	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

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Q4127	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Talymed, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flex hd, or allopatch hd, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2021	12/31/2999
Q4130	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Strattice tm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4132	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix core and grafixpl core, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999
Q4133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999
Q4134	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hmatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4135	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mediskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4136	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ez-derm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4137	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2024	12/31/2999

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Q4138	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence dryflex, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4139	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniomatrix or biodmatrix, injectable, 1 cc	12/1/2020	12/31/2999
Q4140	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4141	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin ac, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4142	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcm biologic tissue matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4143	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repriza, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4145	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epifix, injectable, 1 mg	12/1/2020	12/31/2999
Q4146	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tensix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4147	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Architect, architect px, or architect fx, extracellular matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

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Q4148	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4149	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Excellagen, 0.1 cc	5/15/2021	12/31/2999
Q4150	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allowrap ds or dry, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4151	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioband or guardian, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999
Q4152	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermapure, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4153	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermavest and plurivest, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biovance, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999
Q4155	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neoxflo or clarixflo, 1 mg	12/1/2020	12/31/2999
Q4156	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neox 100 or clarix 100, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4157	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revitalon, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

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Q4158	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Affinity, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2022	12/31/2999
Q4160	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nushield, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4161	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bio-connekt wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4162	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex flow, bioskin flow, 0.5 cc	12/1/2020	12/31/2999
Q4163	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex, bioskin, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4164	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Helicoll, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4165	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Keramatrix or kerasorb, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4166	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cytal, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4167	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Truskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioband, 1 mg	8/1/2018	12/31/2999
Q4169	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent wound, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4170	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4171	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interfyl, 1 mg	12/1/2020	12/31/2999
Q4173	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen or palingen xplus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4174	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen or promatrx, 0.36 mg per 0.25 cc	12/1/2020	12/31/2999
Q4175	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miroderm, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2021	12/31/2999
Q4176	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neopatch or therion, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4177	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Floweramnioflo, 0.1 cc	12/1/2020	12/31/2999
Q4178	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Floweramniopatch, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4179	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Flowerderm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4180	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revita, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4181	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio wound, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4182	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcyte, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4183	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4184	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta or cellesta duo, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4185	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	12/1/2020	12/31/2999
Q4186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epifix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2020	12/31/2999
Q4187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epicord, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2020	12/31/2999
Q4188	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioarmor, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4189	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac, 1 mg	12/1/2020	12/31/2999
Q4190	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4191	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restorigin, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4192	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restorigin, 1 cc	12/1/2020	12/31/2999
Q4193	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Coll-e-derm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4194	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novachor, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4195	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4196	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply am, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4197	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply xt, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4198	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Genesis amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4199	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
Q4200	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Skin te, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4201	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matrion, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4202	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Keroxx (2.5g/cc), 1cc	5/15/2021	12/31/2999
Q4203	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Derma-gide, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4204	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4205	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Membrane graft or membrane wrap, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4206	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Fluid flow or fluid GF, 1 cc	12/1/2020	12/31/2999
Q4208	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novafix, per square cenitmeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4209	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4211	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnion bio or axobiomembrane, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4212	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allogen, per cc	12/1/2020	12/31/2999
Q4213	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ascent, 0.5 mg	12/1/2020	12/31/2999
Q4214	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta cord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4215	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl ambient or axolotl cryo, 0.1 mg	12/1/2020	12/31/2999
Q4216	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent cord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4217	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundfix, biowound, woundfix plus, biowound plus, woundfix xplus or biowound xplus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4218	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgicord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4219	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft-dual, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4220	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bellacell hd or surederm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4221	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniowrap2, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4222	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Progenamatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4224	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Human health factor 10 amniotic patch (hhf10-p), per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4225	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniobind or dermabind tl, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4226	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MyOwn skin, includes harvesting and preparation procedures, per square centimeter	10/1/2024	12/31/2999
Q4227	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4229	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4230	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex flowable amnion, per 0.5 cc	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4232	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4233	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surfactor or nudyn, per 0.5 cc	12/1/2020	12/31/2999
Q4234	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellerate, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4235	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniorepair or altiply, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4236	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Carepatch, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4237	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cryo-cord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4238	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Derm-maxx, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2022	12/31/2999
Q4239	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio-maxx or amnio-maxx lite, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4240	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corecyte, for topical use only, per 0.5 cc	12/1/2020	12/31/2999
Q4241	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Polycyte, for topical use only, per 0.5 cc	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4242	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocyte plus, per 0.5 cc	12/1/2020	12/31/2999
Q4245	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniotext, per cc	12/1/2020	12/31/2999
Q4246	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Coretext or protext, per cc	12/1/2020	12/31/2999
Q4247	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniotext patch, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4248	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermacyte amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4249	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniply, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	3/1/2021	12/31/2999
Q4250	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioamp-mp, per square centimeter (add-on, list separately in addition to primary procedure)	3/1/2021	12/31/2999
Q4251	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vim, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
Q4252	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vendaje, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4253	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Zenith amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
Q4254	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novafix dl, per square centimeter (add-on, list separately in addition to primary procedure)	3/1/2021	12/31/2999
Q4255	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Reguard, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	3/1/2021	12/31/2999
Q4256	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mlg-complete, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4257	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Relese, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4258	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Enverse, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4259	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Celera dual layer or celera dual membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4260	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Signature apatch, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4261	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tag, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4262	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dual layer impax membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgraft tl, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cocoon membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4265	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim tl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4266	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4267	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim dl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4268	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4269	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft xt, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4270	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete sl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4271	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete ft, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4272	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano a, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4273	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aaa, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4274	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano ac, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4275	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aca, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orion, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epieffect, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vendaje ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4280	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcell amnio matrix, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Barrera sl or barrera dl, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4282	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus dual, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biovance tri-layer or biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure)	7/15/2024	12/31/2999
Q4283	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biovance tri-layer or biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4284	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind sl, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4285	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nudyn dl or nudyn dl mesh, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
Q4286	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nudyn sl or nudyn slw, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
Q4287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind dl, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4288	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind ch, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4289	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revoshield + amniotic barrier, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4290	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Membrane wrap-hydro, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4291	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lamellas xt, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4292	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lamellas, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4293	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso dl, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4294	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio quad-core, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4295	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio tri-core amniotic, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4296	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Rebound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4297	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Emerge matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4298	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore pro, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4299	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore pro+, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4300	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso tl, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4301	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Activate matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4302	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete aca, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4303	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete aa, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2024	12/31/2999
Q4305	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion ac tri-layer, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2024	12/31/2999
Q4306	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion ac, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2024	12/31/2999
Q4307	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2024	12/31/2999
Q4308	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sanopellis, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2024	12/31/2999
Q4309	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Via matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2024	12/31/2999
Q4310	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Procenta, per 100 mg	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4311	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4312	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4313	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind fm, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4314	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Reeva ft, per square cenitmeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4315	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Regenelink amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4316	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amchoplast, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4317	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vitograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4318	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	E-graft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4319	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sanograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4320	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pellograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

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Q4321	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Renograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4322	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Caregraft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4323	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloply, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4324	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniotx, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4325	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acapatch, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4326	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundplus, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4327	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Duoamnion, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4328	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Most, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4329	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Singlay, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4330	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Total, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

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Q4331	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl graft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4332	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl dualgraft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4333	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ardeograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4334	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 1, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4335	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 2, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4336	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent c, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4337	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent trident, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4338	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent velos, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4339	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent vericlen, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4340	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simpligraft, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999

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Q4341	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simplimax, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4342	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Theramend, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4343	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermacyte ac matrix amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4344	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tri-membrane wrap, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4345	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matrix hd allograft dermis, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4346	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Shelter dm matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4347	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Rampart dl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4348	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sentry sl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4349	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mantle dl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4350	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palisade dm matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999

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Q4351	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Enclose tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4352	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Overlay sl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4353	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xceed tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen dual-layer membrane and dual-layer palingen x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4355	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend membrane and abiomend hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4357	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap plus, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap dual, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4359	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Choriply, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amchoplast fd, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4361	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epixpress, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4362	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus disk, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon membrane and hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4365	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon dual-layer membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4366	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dual layer amnio burgeon x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4367	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore sl, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchothick, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4369	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioplast 3, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aeroguard, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neoguard, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4372	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchoplast excel, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Membrane wrap lite, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4375	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Duograft ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Duograft aa, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4377	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Trigraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4378	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renew ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4379	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniodefend ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Advograft one, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Advograft dual, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4383	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axolotl graft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4384	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axolotl dualgraft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4385	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Apollo ft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4386	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Acesso trifaca, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4387	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium ft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4388	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium 4l, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4389	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium 4l+, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4390	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ascendion, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4391	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioplast double, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4392	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix duo, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4393	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgraft ac, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4394	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgraft aca, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4395	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Acelagraft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4396	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Natalin, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4397	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit aaa, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4398	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit ac, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit fx, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Polygon3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Absolv3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap 2.0, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap dual plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4404	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap hydro plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap fenestra plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap fenestra, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4407	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap tribus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4408	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap hydro, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4409	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniomatrixf3x, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchomatrixdl, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniomatrixf4x, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Choriofix, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4413	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cygnus solo, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4414	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Simplichor, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard sl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard tl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4417	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard dl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4420	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nuform, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4431	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pma skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4431	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Pma skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4432	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4432	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4433	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4433	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q5009	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)	1/1/2007	12/31/2999
Q5124	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	4/1/2022	12/31/2999
Q5128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	4/1/2023	12/31/2999
Q5133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	4/1/2024	12/31/2999

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Q5134	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	4/1/2024	12/31/2999
Q5135	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	10/1/2024	12/31/2999
Q5138	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	7/15/2024	12/31/2999
Q5147	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	4/1/2025	12/31/2999
Q5148	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	4/1/2025	12/31/2999
Q5149	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	4/1/2025	12/31/2999
Q5150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	4/1/2025	12/31/2999
Q5151	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg	4/1/2025	12/31/2999
Q5152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg	4/1/2025	12/31/2999
Q5153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q5154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, omalizumab-igec (omlyclo), biosimilar, 5 mg	10/1/2025	12/31/2999
Q5155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5156	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5157	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5158	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	1/1/2026	12/31/2999
Q9004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Department of veterans affairs whole health partner services	10/1/2021	12/31/2999
Q9982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	9/1/2020	12/31/2999
Q9983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	9/1/2020	12/31/2999
Q9997	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q9998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg	1/1/2025	12/31/2999
Q9999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg	4/1/2025	12/31/2999
S0122	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, menotropins, 75 iu	1/1/1950	12/31/2999
S0126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, follitropin alfa, 75 iu	1/1/1950	12/31/2999
S0128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, follitropin beta, 75 iu	1/1/1950	12/31/2999
S0155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sterile dilutant for epoprostenol, 50ml	7/27/2009	12/31/2999
S0157	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Becaplermin gel 0. 01%, 0. 5 gm	7/27/2009	12/31/2999
S0194	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DIALYSIS/STRESS VITAMIN SUPPLEMENT, ORAL100 CAPSULES	1/1/1950	12/31/2999
S0197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PRENATAL VITAMINS, 30-DAY SUPPLY	4/1/2005	12/31/2999
S0207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport	1/1/1950	12/31/2999
S0209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair van, mileage, per mile	9/1/2020	12/31/2999

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S0257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/2005	12/31/2999
S0315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Disease management program; initial assessment and initiation of the program	1/1/1950	12/31/2999
S0316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DISEASE MANAGEMENT PROGRAM; FOLLOW-UP/REASSESSMENT	1/1/1950	12/31/2999
S0317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Disease management program; per diem	1/1/1950	12/31/2999
S0320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	1/1/1950	12/31/2999
S0510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-prescription lens (safety, athletic, or sunglass), per lens	1/1/1950	12/31/2999
S0514	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Color contact lens, per lens	1/1/1950	12/31/2999
S0516	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety eyeglass frames	1/1/1950	12/31/2999
S0518	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sunglasses frames	1/1/1950	12/31/2999
S0590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Integral lens service, miscellaneous services reported separately	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR	4/1/2012	12/31/2999
S0622	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)	1/1/1950	12/31/2999
S0800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laser in situ keratomileusis (lasik)	4/15/2008	12/31/2999
S0810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Photorefractive keratectomy (prk)	1/1/2021	12/31/2999
S0812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Phototherapeutic keratectomy (ptk)	7/1/2007	12/31/2999
S1001	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Deluxe item, patient aware (list in addition to code for basic item)	1/1/1950	12/31/2999
S1002	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Customized item (list in addition to code for basic item)	1/1/1950	12/31/2999
S1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use cpt code)	4/15/2009	12/31/2999
S1031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use cpt code)	11/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S1034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/1/2014	12/31/2999
S1035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sensor; invasive (eg, subcutaneous), disposable, for use with artificial pancreas device system, 1 unit = 1 day supply	7/1/2014	12/31/2999
S1036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transmitter; external, for use with artificial pancreas device system	7/1/2014	12/31/2999
S1037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receiver (monitor); external, for use with artificial pancreas device system	7/1/2014	12/31/2999
S1040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT(S)	1/1/1950	12/31/2999
S1091	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stent, non-coronary, temporary, with delivery system (propel)	5/15/2021	12/31/2999
S2080	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laser-assisted uvulopalatoplasty (laup)	9/1/2020	12/31/2999
S2083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	4/1/2004	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2095	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	2/1/2008	12/31/2999
S2102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell tissue transplant from pancreas; allogeneic	9/1/2020	12/31/2999
S2107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adoptive immunotherapy i. E. Development of specific anti-tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	9/1/2020	12/31/2999
S2117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroereisis, subtalar	12/1/2020	12/31/2999
S2118	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Metal-on-metal total hip resurfacing, including acetabular and femoral components	1/15/2025	12/31/2999
S2140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood harvesting for transplantation, allogeneic	2/1/2013	12/31/2999
S2142	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood-derived stem-cell transplantation, allogeneic	2/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999
S2202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Echosclerotherapy	9/24/2012	12/31/2999
S2235	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of auditory brain stem implant	10/1/2003	12/31/2999
S2348	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, USING RADIOFREQUENCY ENERGY, SINGLE OR MULTIPLE LEVELS, LUMBAR	9/1/2020	12/31/2999
S2400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, urinary tract obstruction in the fetus, procedure performed in utero	11/1/2012	12/31/2999
S2402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	11/1/2012	12/31/2999
S2403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	11/1/2012	12/31/2999
S2404	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, myelomeningocele in the fetus, procedure performed in utero	9/24/2012	12/31/2999
S2405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	11/1/2012	12/31/2999
S2409	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	2/15/2007	12/31/2999
S2409	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	10/24/2019	12/31/2999
S2411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	12/1/2022	12/31/2999
S3650	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test, hormone level; during menopause	12/1/2020	12/31/2999
S3652	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test, hormone level; to assess preterm labor risk	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S3655	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Antisperm antibodies test (immunobead)	1/1/1950	12/31/2999
S3722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DOSE OPTIMIZATION BY AREA UNDER THE CURVE (AUC) ANALYSIS, FOR INFUSIONAL 5-FLUOROURACIL	9/1/2020	12/31/2999
S3900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surface electromyography (emg)	1/15/2026	12/31/2999
S3900	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surface electromyography (emg)	12/15/2014	1/14/2026
S4005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interim labor facility global (labor occurring but not resulting in delivery)	1/1/1950	12/31/2999
S4011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/1950	12/31/2999
S4013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete cycle, gamete intrafallopian transfer (gift), case rate	1/1/1950	12/31/2999
S4014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete cycle, zygote intrafallopian transfer (zift), case rate	1/1/1950	12/31/2999
S4015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Complete in vitro fertilization cycle, not otherwise specified, case rate	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S4015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete in vitro fertilization cycle, not otherwise specified, case rate	1/1/1950	12/31/2999
S4016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Frozen in vitro fertilization cycle, case rate	1/1/1950	12/31/2999
S4017	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incomplete cycle, treatment cancelled prior to stimulation, case rate	1/1/1950	12/31/2999
S4018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Frozen embryo transfer procedure cancelled before transfer, case rate	1/1/1950	12/31/2999
S4020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In vitro fertilization procedure cancelled before aspiration, case rate	1/1/1950	12/31/2999
S4021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In vitro fertilization procedure cancelled after aspiration, case rate	1/1/1950	12/31/2999
S4022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, case rate	1/1/1950	12/31/2999
S4023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Donor egg cycle, incomplete, case rate	1/1/1950	12/31/2999
S4024	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Air polymer-type a intrauterine foam, per study dose	4/1/2025	12/31/2999
S4025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Donor services for in vitro fertilization (sperm or embryo), case rate	1/1/1950	12/31/2999
S4026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Procurement of donor sperm from sperm bank	1/1/1950	12/31/2999
S4027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage of previously frozen embryos	1/1/1950	12/31/2999
S4028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Microsurgical epididymal sperm aspiration (mesa)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S4030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; initial visit	1/1/1950	12/31/2999
S4031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; subsequent visit	1/1/1950	12/31/2999
S4035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Stimulated intrauterine insemination (iui), case rate	1/1/1950	12/31/2999
S4037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreserved embryo transfer, case rate	1/1/1950	12/31/2999
S4040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Monitoring and storage of cryopreserved embryos, per 30 days	1/1/1950	12/31/2999
S4042	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MANAGEMENT OF OVULATION INDUCTION (INTERPRETATION OF DIAGNOSTIC TESTS AND STUDIES, NON-FACE-TO-FACE MEDICAL MANAGEMENT OF THE PATIENT), PER CYCLE	1/1/2005	12/31/2999
S4990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, legend	1/1/1950	12/31/2999
S4991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, non-legend	1/1/1950	12/31/2999
S4995	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Smoking cessation gum	1/1/1950	12/31/2999
S5100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per 15 minutes	1/1/1950	12/31/2999
S5101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per half day	1/1/1950	12/31/2999
S5102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per diem	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, center-based; services not included in program fee, per diem	1/1/1950	12/31/2999
S5108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training to home care client, per 15 minutes	1/1/1950	12/31/2999
S5109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training to home care client, per session	1/1/1950	12/31/2999
S5110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, family; per 15 minutes	1/1/1950	12/31/2999
S5111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, family; per session	1/1/1950	12/31/2999
S5115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, non-family; per 15 minutes	1/1/1950	12/31/2999
S5116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, non-family; per session	1/1/1950	12/31/2999
S5120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per 15 minutes	1/1/1950	12/31/2999
S5121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per diem	1/1/1950	12/31/2999
S5125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Attendant care services; per 15 minutes	1/1/1950	12/31/2999
S5126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Attendant care services; per diem	1/1/1950	12/31/2999
S5130	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per 15 minutes	1/1/1950	12/31/2999
S5130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per 15 minutes	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5131	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per diem	1/1/1950	12/31/2999
S5131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per diem	1/1/1950	12/31/2999
S5135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per 15 minutes	1/1/1950	12/31/2999
S5136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per diem	1/1/1950	12/31/2999
S5140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per diem	1/1/1950	12/31/2999
S5141	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per month	1/1/1950	12/31/2999
S5145	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per diem	1/1/1950	12/31/2999
S5146	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per month	1/1/1950	12/31/2999
S5150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unskilled respite care, not hospice; per 15 minutes	1/1/1950	12/31/2999
S5151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unskilled respite care, not hospice; per diem	1/1/1950	12/31/2999
S5160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; installation and testing	1/1/1950	12/31/2999
S5161	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; service fee, per month (excludes installation and testing)	1/1/1950	12/31/2999
S5162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; purchase only	1/1/1950	12/31/2999
S5165	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home modifications; per service	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home delivered meals, including preparation; per meal	1/1/1950	12/31/2999
S5175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laundry service, external, professional; per order	1/1/1950	12/31/2999
S5181	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home health respiratory therapy, nos, per diem	10/24/2019	12/31/2999
S5185	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medication reminder service, non-face-to-face; per month	1/1/1950	12/31/2999
S5199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Personal care item, nos, each	1/1/1950	12/31/2999
S5199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Personal care item, nos, each	1/1/1950	12/31/2999
S5497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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	10/24/2019	12/31/2999
S8035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic source imaging	4/1/2009	12/31/2999
S8040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Topographic brain mapping	12/15/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S8080	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical	9/1/2020	12/31/2999
S8130	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	12/15/2014	12/31/2999
S8131	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	12/15/2014	12/31/2999
S8185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flutter device	1/1/1950	12/31/2999
S8189	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Tracheostomy supply, not otherwise classified	1/1/1950	12/31/2999
S8270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enuresis alarm, using auditory buzzer and/or vibration device	7/1/2005	12/31/2999
S8301	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infection control supplies, not otherwise specified	1/1/1950	12/31/2999
S8930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	9/1/2020	12/31/2999
S8948	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S8990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Physical or manipulative therapy performed for maintenance rather than restoration	9/1/2020	12/31/2999
S9002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	4/1/2024	12/31/2999
S9055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Procuren or other growth factor preparation to promote wound healing	9/1/2020	12/31/2999
S9090	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vertebral axial decompression, per session	12/15/2014	12/31/2999
S9125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Respite care, in the home, per diem	3/1/2008	12/31/2999
S9145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin pump initiation, instruction in initial use of pump (pump not included)	1/1/1950	12/31/2999
S9340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/14/2009	12/31/2999
S9341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/14/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/14/2009	12/31/2999
S9343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/27/2009	12/31/2999
S9355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	10/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	9/14/2009	12/31/2999
S9366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/14/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	9/14/2009	12/31/2999
S9368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	9/14/2009	12/31/2999
S9379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9381	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Delivery or service to high risk areas requiring escort or extra protection, per visit	1/1/1950	12/31/2999
S9401	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anticoagulation clinic, inclusive of all services except laboratory tests, per session	1/1/1950	12/31/2999
S9430	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharmacy compounding and dispensing services	9/1/2020	12/31/2999
S9432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical foods for non-inborn errors of metabolism	10/1/2021	12/31/2999
S9434	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Modified solid food supplements for inborn errors of metabolism	1/1/1950	12/31/2999
S9435	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Medical foods for inborn errors of metabolism	7/27/2009	12/31/2999
S9436	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Childbirth preparation/lamaze classes, non-physician provider, per session	1/1/1950	12/31/2999
S9437	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Childbirth refresher classes, non-physician provider, per session	1/1/1950	12/31/2999
S9438	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cesarean birth classes, non-physician provider, per session	1/1/1950	12/31/2999
S9439	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vbac (vaginal birth after cesarean) classes, non-physician provider, per session	1/1/1950	12/31/2999
S9441	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Asthma education, non-physician provider, per session	1/1/1950	12/31/2999
S9442	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Birthing classes, non-physician provider, per session	1/1/1950	12/31/2999
S9444	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Parenting classes, non-physician provider, per session	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9445	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, individual, per session	1/1/1950	12/31/2999
S9445	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient education, not otherwise classified, non-physician provider, individual, per session	1/1/1950	12/31/2999
S9446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, group, per session	1/1/1950	12/31/2999
S9446	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient education, not otherwise classified, non-physician provider, group, per session	1/1/1950	12/31/2999
S9447	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Infant safety (including cpr) classes, non-physician provider, per session	1/1/1950	12/31/2999
S9449	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Weight management classes, non-physician provider, per session	1/1/1950	12/31/2999
S9451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Exercise classes, non-physician provider, per session	1/1/1950	12/31/2999
S9454	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Stress management classes, non-physician provider, per session	1/1/1950	12/31/2999
S9472	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardiac rehabilitation program, non-physician provider, per diem	1/1/1950	12/31/2999
S9473	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pulmonary rehabilitation program, non-physician provider, per diem	2/1/2008	12/31/2999
S9482	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9537	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2011	12/31/2999
S9542	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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	10/24/2019	12/31/2999
S9558	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	7/15/2015	12/31/2999
S9810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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)	7/27/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9810	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	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)	10/24/2019	12/31/2999
S9900	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM	1/1/1950	12/31/2999
S9960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	1/1/2014	12/31/2999
S9961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	1/1/2014	12/31/2999
S9970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health club membership, annual	1/1/1950	12/31/2999
S9976	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lodging, per diem, not otherwise classified	1/1/1950	12/31/2999
S9976	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging, per diem, not otherwise classified	1/1/1950	12/31/2999
S9977	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Meals, per diem, not otherwise specified	1/1/1950	12/31/2999
S9977	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals, per diem, not otherwise specified	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9981	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical records copying fee, administrative	1/1/1950	12/31/2999
S9982	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical records copying fee, per page	1/1/1950	12/31/2999
S9986	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Not medically necessary service (patient is aware that service not medically necessary)	1/1/1950	12/31/2999
S9988	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase i clinical trial	1/1/1950	12/31/2999
S9989	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided outside of the united states of america (list in addition to code(s) for services(s))	1/1/1950	12/31/2999
S9990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase ii clinical trial	1/1/1950	12/31/2999
S9991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase iii clinical trial	1/1/1950	12/31/2999
S9992	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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	1/1/1950	12/31/2999
S9994	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion	1/1/1950	12/31/2999
S9996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals for clinical trial participant and one caregiver/companion	1/1/1950	12/31/2999
S9999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sales tax	6/1/2014	12/31/2999
T1005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Respite care services, up to 15 minutes	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T1006	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol and/or substance abuse services, family/couple counseling	1/1/1950	12/31/2999
T1009	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Child sitting services for children of the individual receiving alcohol and/or substance abuse services	1/1/1950	12/31/2999
T1010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program)	1/1/1950	12/31/2999
T1012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol and/or substance abuse services, skills development	1/1/1950	12/31/2999
T1013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sign language or oral interpretive services, per 15 minutes	1/1/1950	12/31/2999
T1014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telehealth transmission, per minute, professional services bill separately	1/1/1950	12/31/2999
T1018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	School-based individualized education program (iep) services, bundled	1/1/1950	12/31/2999
T1019	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	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)	1/1/1950	12/31/2999
T1029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling	1/1/1950	12/31/2999
T1032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by a doula birth worker, per 15 minutes	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T1033	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by a doula birth worker, per diem	10/1/2022	12/31/2999
T1505	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRONIC MEDICATION COMPLIANCE MANAGEMENT DEVICE, INCLUDES ALL COMPONENTS AND ACCESSORIES, NOT OTHERWISE CLASSIFIED	10/24/2019	12/31/2999
T1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks	10/24/2019	12/31/2999
T2001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; patient attendant/escort	1/1/1950	12/31/2999
T2002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; per diem	1/1/1950	12/31/2999
T2003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; encounter/trip	1/1/1950	12/31/2999
T2004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transport; commercial carrier, multi-pass	1/1/1950	12/31/2999
T2005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; stretcher van	1/1/1950	12/31/2999
T2007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	1/1/1950	12/31/2999
T2012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational; waiver, per diem	7/1/2008	12/31/2999
T2012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, educational; waiver, per diem	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2013	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational, waiver; per hour	7/1/2008	12/31/2999
T2013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, educational, waiver; per hour	1/1/1950	12/31/2999
T2014	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per diem	7/1/2008	12/31/2999
T2014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, prevocational, waiver; per diem	1/1/1950	12/31/2999
T2015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per hour	7/1/2008	12/31/2999
T2015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, prevocational, waiver; per hour	1/1/1950	12/31/2999
T2016	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; per diem	7/1/2008	12/31/2999
T2016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, residential, waiver; per diem	1/1/1950	12/31/2999
T2017	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; 15 minutes	7/1/2008	12/31/2999
T2017	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, residential, waiver; 15 minutes	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2018	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per diem	7/1/2008	12/31/2999
T2018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, supported employment, waiver; per diem	1/1/1950	12/31/2999
T2019	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per 15 minutes	7/1/2008	12/31/2999
T2019	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, supported employment, waiver; per 15 minutes	1/1/1950	12/31/2999
T2020	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per diem	7/1/2008	12/31/2999
T2020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day habilitation, waiver; per diem	1/1/1950	12/31/2999
T2021	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per 15 minutes	7/1/2008	12/31/2999
T2021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day habilitation, waiver; per 15 minutes	1/1/1950	12/31/2999
T2024	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service assessment/plan of care development, waiver	7/1/2008	12/31/2999
T2025	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Waiver services; not otherwise specified (nos)	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2026	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per diem	7/1/2008	12/31/2999
T2026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized childcare, waiver; per diem	1/1/1950	12/31/2999
T2027	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per 15 minutes	7/1/2008	12/31/2999
T2027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized childcare, waiver; per 15 minutes	1/1/1950	12/31/2999
T2028	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized supply, not otherwise specified, waiver	7/1/2008	12/31/2999
T2028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized supply, not otherwise specified, waiver	1/1/1950	12/31/2999
T2029	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized medical equipment, not otherwise specified, waiver	10/24/2019	12/31/2999
T2029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized medical equipment, not otherwise specified, waiver	1/1/1950	12/31/2999
T2030	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living, waiver; per month	7/1/2008	12/31/2999
T2031	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living; waiver, per diem	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2032	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per month	7/1/2008	12/31/2999
T2033	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per diem	7/1/2008	12/31/2999
T2034	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Crisis intervention, waiver; per diem	7/1/2008	12/31/2999
T2034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Crisis intervention, waiver; per diem	1/1/1950	12/31/2999
T2035	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Utility services to support medical equipment and assistive technology/devices, waiver	7/1/2008	12/31/2999
T2035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Utility services to support medical equipment and assistive technology/devices, waiver	1/1/1950	12/31/2999
T2036	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, overnight, waiver; each session	7/1/2008	12/31/2999
T2036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic camping, overnight, waiver; each session	1/1/1950	12/31/2999
T2037	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, day, waiver; each session	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic camping, day, waiver; each session	1/1/1950	12/31/2999
T2038	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Community transition, waiver; per service	7/1/2008	12/31/2999
T2038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community transition, waiver; per service	1/1/1950	12/31/2999
T2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vehicle modifications, waiver; per service	7/1/2008	12/31/2999
T2039	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vehicle modifications, waiver; per service	1/1/1950	12/31/2999
T2040	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Financial management, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999
T2040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Financial management, self-directed, waiver; per 15 minutes	1/1/1950	12/31/2999
T2041	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supports brokerage, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999
T2041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supports brokerage, self-directed, waiver; per 15 minutes	1/1/1950	12/31/2999
T2049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	NON-EMERGENCY TRANSPORTATION; STRETCHER VAN, MILEAGE; PER MILE	7/1/2004	12/31/2999
T2050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Financial management, self-directed, waiver; per diem	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supports brokerage, self-directed, waiver; per diem	4/1/2022	12/31/2999
T2101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Human breast milk processing, storage and distribution only	1/1/1950	12/31/2999
T4521	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH	1/1/2005	12/31/2999
T4522	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH	1/1/2005	12/31/2999
T4523	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH	1/1/2005	12/31/2999
T4524	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH	1/1/2005	12/31/2999
T4525	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH	1/1/2005	12/31/2999
T4526	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH	1/1/2005	12/31/2999
T4527	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	1/1/2005	12/31/2999
T4528	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH	1/1/2005	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T4538	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DIAPER SERVICE, REUSABLE DIAPER, EACH DIAPER	1/1/2005	12/31/2999
T4539	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUSABLE, ANY SIZE, EACH	1/1/2005	12/31/2999
T4540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH	1/1/2005	12/31/2999
T4541	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH	1/1/2005	12/31/2999
T4542	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, SMALL SIZE, EACH	1/1/2005	12/31/2999
T4543	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each	1/1/2007	12/31/2999
T5001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	POSITIONING SEAT FOR PERSONS WITH SPECIAL ORTHOPEDIC NEEDS	1/1/1950	12/31/2999
T5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supply, not otherwise specified	7/1/2008	12/31/2999
V2199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, single vision lens	10/24/2019	12/31/2999
V2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Contact lens, other type	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Scleral cover shell	6/5/2018	12/31/2999
V2629	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic eye, other type	1/1/1950	12/31/2999
V2702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DELUXE LENS FEATURE	1/1/2005	12/31/2999
V2745	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	1/1/1950	12/31/2999
V2756	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Eye glass case	1/1/1950	12/31/2999
V2761	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mirror coating, any type, solid, gradient or equal, any lens material, per lens	1/1/1950	12/31/2999
V2762	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Polarization, any lens material, per lens	1/1/1950	12/31/2999
V2782	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lens, index 1. 54 to 1. 65 plastic or 1. 60 to 1. 79 glass, excludes polycarbonate, per lens	1/1/1950	12/31/2999
V2783	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lens, index greater than or equal to 1. 66 plastic or greater than or equal to 1. 80 glass, excludes polycarbonate, per lens	1/1/1950	12/31/2999
V2787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	10/15/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	10/15/2008	12/31/2999
V2790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniotic membrane for surgical reconstruction, per procedure	7/1/2020	12/31/2999
V2797	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vision supply, accessory and/or service component of another hcpcs vision code	1/1/1950	12/31/2999
V2799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vision item or service, miscellaneous	10/24/2019	12/31/2999
V5090	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dispensing fee, unspecified hearing aid	10/24/2019	12/31/2999
V5267	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	1/1/1950	12/31/2999
V5269	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, alerting, any type	1/1/1950	12/31/2999
V5270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, television amplifier, any type	1/1/1950	12/31/2999
V5271	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, television caption decoder	1/1/1950	12/31/2999
V5272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, tdd	1/1/1950	12/31/2999
V5273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, for use with cochlear implant	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V5274	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, not otherwise specified	1/1/1950	12/31/2999
V5274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, not otherwise specified	1/1/1950	12/31/2999
V5287	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, personal fm/dm receiver, not otherwise specified	10/24/2019	12/31/2999
V5298	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid, not otherwise classified	1/1/1950	12/31/2999
V5299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing service, miscellaneous	1/1/1950	12/31/2999

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

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

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

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