BlueCross BlueShield of Texas

2025 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List - Fully Insured
Effective 1/1/2025 through 1/1/2026
(Updated April 2025)

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System codes that, based on our medical policy, are:
- Subject to a medical necessity review,
- Candidates for a Recommended Clinical Review,
- Not a benefit for our members,
- Considered experimental, investigational and unproven (EIU), or
- Not on our prior authorization list (with some exceptions based on members' benefit plans)
Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025

Utilization Management Process

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

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Rotary Wing & Ground Ambulance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Managed by Alacura.
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
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/16/2019	12/31/2999
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2012	12/31/2999
0312U	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	5/14/2025
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/16/2019	12/31/2999
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0402T	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
0407U	Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported as risk for progressive decline in kidney function	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2024	5/14/2025
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2017	12/31/2999
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2020	12/31/2999
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2024	12/31/2999
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2024	12/31/2999
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0572T	Insertion of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0573T	Removal of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0580T	Removal of substernal implantable defibrillator pulse generator only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
0692T	Therapeutic ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2024	12/31/2999
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2023	12/31/2999
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
0811T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
0812T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2024	12/31/2999
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
0868T	High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, with interpretation and report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2024	5/14/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	2/28/2025
0947T	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
9701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2006	12/31/2999
11970	Replacement of tissue expander with permanent implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2006	12/31/2999
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
15758	Free fascial flap with microvascular anastomosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2010	12/31/2999
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
15775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15776	Punch graft for hair transplant; more than 15 punch grafts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2005	12/31/2999
15788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
15876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15879	Suction assisted lipectomy; lower extremity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
17380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
19300	Mastectomy for gynecomastia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
19303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
19318	Breast reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2023	12/31/2999
19325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19342	Insertion or replacement of breast implant on separate day from mastectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2005	12/31/2999
19350	Nipple/areola reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19355	Correction of inverted nipples	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
19499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
21032	Excision of maxillary torus palatinus	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21083	Impression and custom preparation; palatal lift prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21121	Genioplasty; sliding osteotomy, single piece	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
27299	Unlisted procedure, pelvis or hip joint	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
27702	Arthroplasty, ankle; with implant (total ankle)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/15/2009	12/31/2999
27703	Arthroplasty, ankle; revision, total ankle	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2015	12/31/2999
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2007	12/31/2999
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
29916	Arthroscopy, hip, surgical; with labral repair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2011	12/31/2999
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	5/14/2025
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	5/14/2025
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2007	12/31/2999
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33213	Insertion of pacemaker pulse generator only; with existing dual leads	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2006	12/31/2999
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2015	12/31/2999
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2016	12/31/2999
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
33928	Removal and replacement of total replacement heart system (artificial heart)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2019	12/31/2999
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2006	12/31/2999
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2014	12/31/2999
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37718	Ligation, division, and stripping, short saphenous vein	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2006	12/31/2999
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38232	Bone marrow harvesting for transplantation; autologous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38242	Allogeneic lymphocyte infusions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
38243	Hematopoietic progenitor cell (HPC); HPC boost	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38308	Lymphangiotomy or other operations on lymphatic channels	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2014	12/31/2999
41120	Glossectomy; less than one-half tongue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
41512	Tongue base suspension, permanent suture technique	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
41872	Gingivoplasty, each quadrant (specify)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
42140	Uvulectomy, excision of uvula	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2010	12/31/2999
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2017	12/31/2999
43289	Unlisted laparoscopy procedure, esophagus	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
43632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2023	12/31/2999
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2007	12/31/2999
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2009	12/31/2999
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2016	12/31/2999
50541	Laparoscopy, surgical; ablation of renal cysts	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2005	12/31/2999
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
54125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54401	Insertion of penile prosthesis; inflatable (self-contained)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
54660	Insertion of testicular prosthesis (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2013	12/31/2999
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2007	12/31/2999
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
55899	Unlisted procedure, male genital system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2017	12/31/2999
55970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
55980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
56805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
57291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2006	12/31/2999
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2010	12/31/2999
58321	Artificial insemination; intra-cervical	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58322	Artificial insemination; intra-uterine	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58323	Sperm washing for artificial insemination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
58750	Tubotubal anastomosis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/15/2008	12/31/2999
59072	Fetal umbilical cord occlusion, including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
59076	Fetal shunt placement, including ultrasound guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
60699	Unlisted procedure, endocrine system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
62268	Percutaneous aspiration, spinal cord cyst or syrinx	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63273	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	5/14/2025
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
64620	Destruction by neurolytic agent, intercostal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2023	12/31/2999
64640	Destruction by neurolytic agent; other peripheral nerve or branch	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
65760	Keratomileusis	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
65772	Corneal relaxing incision for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
65775	Corneal wedge resection for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
65785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2012	12/31/2999
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2022	12/31/2999
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2022	12/31/2999
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
69090	Ear piercing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2020	12/31/2999
69300	Otoplasty, protruding ear, with or without size reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
76120	Cineradiography/videoradiography, except where specifically included	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
76125	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2005	12/31/2999
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
86911	Blood typing, for paternity testing, per individual; each additional antigen system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88000	Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88012	Necropsy (autopsy), gross examination only; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88025	Necropsy (autopsy), gross and microscopic; with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88027	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88028	Necropsy (autopsy), gross and microscopic; infant with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88040	Necropsy (autopsy); forensic examination	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88045	Necropsy (autopsy); coroner's call	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
88099	Unlisted necropsy (autopsy) procedure	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
89258	Cryopreservation; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
89259	Cryopreservation; sperm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
89335	Cryopreservation, reproductive tissue, testicular	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89337	Cryopreservation, mature oocyte(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2019	12/31/2999
89342	Storage (per year); embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89343	Storage (per year); sperm/semen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89344	Storage (per year); reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
89346	Storage (per year); oocyte(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89352	Thawing of cryopreserved; embryo(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89353	Thawing of cryopreserved; sperm/semen, each aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3/20/2018	12/31/2999
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
89356	Thawing of cryopreserved; oocytes, each aliquot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2010	12/31/2999
90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2010	12/31/2999
90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2010	12/31/2999
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
92065	Orthoptic training; performed by a physician or other qualified health care professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2013	12/31/2999
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2020	12/31/2999
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2005	12/31/2999
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
94452	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
94453	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
95981	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) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
95982	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) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
96000	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96001	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2010	12/31/2999
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2009	12/31/2999
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2010	12/31/2999
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
97545	Work hardening/conditioning; initial 2 hours	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99075	Medical testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99082	Unusual travel (eg, transportation and escort of patient)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99175	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99360	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
99509	Home visit for assistance with activities of daily living and personal care	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0021	Ambulance service, outside state per mile, transport (medicaid only)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
A0080	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0090	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0100	Non-emergency transportation; taxi	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0110	Non-emergency transportation and bus, intra or inter state carrier	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0130	Non-emergency transportation: wheel-chair van	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0140	Non-emergency transportation and air travel (private or commercial) intra or inter state	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0160	Non-emergency transportation: per mile - case worker or social worker	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0170	Transportation ancillary: parking fees, tolls, other	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0180	Non-emergency transportation: ancillary: lodging-recipient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0190	Non-emergency transportation: ancillary: meals-recipient	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0200	Non-emergency transportation: ancillary: lodging escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0210	Non-emergency transportation: ancillary: meals-escort	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2014	12/31/2999
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2007	12/31/2999
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
A0888	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
A2027	Matriderm, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
A2028	Micromatrix flex, per mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
A2029	Mirotract wound matrix sheet, per cubic centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
A4244	Alcohol or peroxide, per pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4246	Betadine or phisohex solution, per pint	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4247	Betadine or iodine swabs/wipes, per box	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4335	Incontinence supply; miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4342	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
A4450	Tape, non-waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4452	Tape, waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4458	Enema bag with tubing, reusable	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4465	Non-elastic binder for extremity	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4490	Surgical stockings above knee length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4495	Surgical stockings thigh length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4500	Surgical stockings below knee length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4510	Surgical stockings full length, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A4541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
A4554	Disposable underpads, all sizes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
A4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE (E.G., TENS, NMES), PER OZ	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4638	Replacement battery for patient-owned ear pulse generator, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
A4890	Contracts, repair and maintenance, for hemodialysis equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4927	Gloves, non-sterile, per 100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4931	Oral thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A4932	Rectal thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without adhesive border, each dressing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A6217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But less than or equal to 48 sq. In. , without adhesive border, each dressing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In. , without adhesive border, each dressing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A6530	Gradient compression stocking, below knee, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6531	Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6533	Gradient compression stocking, thigh length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6534	Gradient compression stocking, thigh length, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6536	Gradient compression stocking, full length/chap style, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6537	Gradient compression stocking, full length/chap style, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6539	Gradient compression stocking, waist length, 18-30 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6540	Gradient compression stocking, waist length, 30-40 mmhg, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6544	Gradient compression stocking, garter belt	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A6549	Gradient compression garment, not otherwise specified, for daytime use, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
A9150	Non-prescription drugs	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A9152	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A9153	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
A9268	Programmer for transient, orally ingested capsule	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2025	12/31/2999
A9269	Programable, transient, orally ingested capsule, for use with external programmer, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2025	12/31/2999
A9270	Non-covered item or service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2011	12/31/2999
A9282	WIG, ANY TYPE, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
A9291	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
A9300	Exercise equipment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
B4102	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4103	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2019	12/31/2999
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2013	12/31/2999
B4158	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4159	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4160	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C1761	Catheter, transluminal intravascular lithotripsy, coronary	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
C1764	Event recorder, cardiac (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
C1778	Lead, neurostimulator (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2015	12/31/2999
C1817	Septal defect implant system, intracardiac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2014	12/31/2999
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/15/2025	12/31/2999
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C1824	Generator, cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/16/2019	12/31/2999
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2023	12/31/2999
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2014	12/31/2999
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2015	12/31/2999
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9765	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2021	12/31/2999
C9782	Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2024	12/31/2999
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7230	removal of impacted tooth - partially bony	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D8210	removable appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
D8220	fixed appliance therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0162	Sitz bath chair	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0183	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
E0187	Water pressure mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
E0190	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2/1/2010	12/31/2999
E0210	Electric heat pad, standard	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0215	Electric heat pad, moist	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0217	Water circulating heat pad with pump	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2006	12/31/2999
E0218	Fluid circulating cold pad with pump, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0236	Pump for water circulating pad	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0240	Bath/shower chair, with or without wheels, any size	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0241	Bath tub wall rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0242	Bath tub rail, floor base	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0243	Toilet rail, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0244	Raised toilet seat	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0247	Transfer bench for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0248	Transfer bench, heavy duty, for tub or toilet with or without commode opening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0249	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2006	12/31/2999
E0273	Bed board	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0274	Over-bed table	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0280	Bed cradle, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
E0291	Hospital bed, fixed height, without side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2014	12/31/2999
E0315	Bed accessory: board, table, or support device, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
E0462	Rocking bed with or without side rails	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
E0616	Implantable cardiac event recorder with memory, activator and programmer	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0620	Skin piercing device for collection of capillary blood, laser, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0677	Non-pneumatic sequential compression garment, trunk	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
E0678	Non-pneumatic sequential compression garment, full leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0679	Non-pneumatic sequential compression garment, half leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0681	Non-pneumatic compression controller without calibrated gradient pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0682	Non-pneumatic sequential compression garment, full arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2006	12/31/2999
E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
E0736	Transcutaneous tibial nerve stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0755	Electronic salivary reflex stimulator (intra-oral/non-invasive)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2017	12/31/2999
E0920	Fracture frame, attached to bed, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0946	Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2005	12/31/2999
E0948	Fracture frame, attachments for complex cervical traction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E0984	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E0985	Wheelchair accessory, seat lift mechanism	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0986	Manual wheelchair accessory, push-rim activated power assist system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1005	Wheelchair accessory, power seatng system, recline only, with power shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
E1083	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1087	High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1170	Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1171	Amputee wheelchair, fixed full length arms, without footrests or legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1172	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1195	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E1227	Special height arms for wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1228	Special back height for wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E1300	Whirlpool, portable (overtub type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E1301	Whirlpool tub, walk-in, portable	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
E1310	Whirlpool, non-portable (built-in type)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1355	Stand/rack	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E1700	Jaw motion rehabilitation system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E1701	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E1702	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
E2120	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2006	12/31/2999
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
E2301	Wheelchair accessory, power standing system, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2007	12/31/2999
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2007	12/31/2999
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2324	Power wheelchair accessory, chin cup for chin control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2360	Power wheelchair accessory, 22 nf non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2361	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2364	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2365	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2511	Speech generating software program, for personal computer or personal digital assistant	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2512	Accessory for speech generating device, mounting system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2513	Accessory for speech generating device, electromyographic sensor	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
E2599	Accessory for speech generating device, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2014	12/31/2999
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
G0553	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
G0554	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2021	12/31/2999
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8399	Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8400	Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8415	FOOTWEAR EVALUATION WAS NOT PERFORMED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8416	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8417	Bmi is documented above normal parameters and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8418	Bmi is documented below normal parameters and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8419	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8420	Bmi is documented within normal parameters and no follow-up plan is required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8421	Bmi not documented and no reason is given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8428	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8430	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8432	Depression screening not documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8433	Screening for depression not completed, documented patient or medical reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8450	Beta-blocker therapy prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8451	Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8452	Beta-blocker therapy not prescribed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8465	High or very high risk of recurrence of prostate cancer	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8474	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8478	Blood pressure measurement not performed or documented, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
G8559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8563	Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8564	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8565	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8566	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS MEASURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8567	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8568	Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8569	Prolonged postoperative intubation (> 24 hrs) required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8570	Prolonged postoperative intubation (> 24 hrs) not required	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8575	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED DIALYSIS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8576	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8577	Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8578	Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8598	Aspirin or another antiplatelet therapy used	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8599	Aspirin or another antiplatelet therapy not used, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8600	Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8601	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8602	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G9050	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9051	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9053	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9056	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9058	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9059	Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9060	Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9061	Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9062	Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9063	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage i (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9064	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage ii (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9065	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9066	Oncology; disease status; limited to non-small cell lung cancer; stage iii b-iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9067	Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9068	Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9069	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9070	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9071	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9072	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9073	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9074	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9075	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9077	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9078	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9079	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9080	Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9083	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9084	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9085	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9086	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9087	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9088	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9089	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9090	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9091	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9092	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9093	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9094	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9095	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9099	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9100	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9101	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9102	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9103	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9104	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9105	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9106	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9107	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9108	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9109	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9110	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9111	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9112	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9113	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9114	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9115	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9116	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9117	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9123	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9124	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9125	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9126	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9129	Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9130	Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48 HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS PREVENT TRANSFER; PAYMENT IS MADE ON EACH PERIOD UP TO 4 HOURS, AFTER THE FIRST 4 HOURS	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2008	12/31/2999
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
J0174	Injection, lecanemab-irmb, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2023	12/31/2999
J0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2023	12/31/2999
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2008	12/31/2999
J0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2021	12/31/2999
J0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
J0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2024	12/31/2999
J0600	Injection, edetate calcium disodium, up to 1000 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999
J0888	Injectin, epoetin beta, 1 microgram, (for non esrd use)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
J1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
J1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2020	12/31/2999
J1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1306	Injection, inclisiran, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1307	Injection, crovalimab-akkz, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J1426	Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
J1427	Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2021	12/31/2999
J1428	Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
J1429	Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
J1440	Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2024	12/31/2999
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J1628	Injection, guselkumab, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2025	12/31/2999
J1632	Injection, brexanolone, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	2/14/2025
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/15/2023	12/31/2999
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2023	12/31/2999
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1930	INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2023	12/31/2999
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J2356	Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J2782	Injection, avacincaptad pegol, 0.1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/1/2020	12/31/2999
J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
J3111	Injection, romosozumab-aqqg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J3241	Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2020	12/31/2999
J3247	Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2024	12/31/2999
J3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/15/2022	12/31/2999
J3393	Injection, betibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3396	INJECTION, VERTEPORFIN, 0.1 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2007	12/31/2999
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2020	12/31/2999
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J3520	Edetate disodium, per 150 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
J3570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	6/1/2015	12/31/2999
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/15/2011	12/31/2999
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
J7355	Injection, travoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2023	12/31/2999
J9037	Injection, belantamab mafodontin-blmf, 0.5 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	3/31/2025
J9057	Injection, copanlisib, 1 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9285	Injection, olaratumab, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2019	12/31/2999
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
J9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9333	Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2024	12/31/2999
J9376	Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2024	12/31/2999
J9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2006	12/31/2999
K0010	Standard - weight frame motorized/power wheelchair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0011	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0014	Other motorized/power wheelchair base	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2011	12/31/2999
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

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K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

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K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999

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K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K0899	Power mobile device; no dme pdac	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2006	12/31/2999
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2022	12/31/2999
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L1834	Knee orthosis, without knee joint, rigid, custom-fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3060	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5611	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5613	Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5614	Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5620	Addition to lower extremity, test socket, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5624	Addition to lower extremity, test socket, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5629	Addition to lower extremity, below knee, acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5638	Addition to lower extremity, below knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5640	Addition to lower extremity, knee disarticulation, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2007	12/31/2999
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2007	12/31/2999
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2013	12/31/2999
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2015	12/31/2999
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
L5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
L5974	All lower extremity prostheses, foot, single axis ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5976	All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5980	All lower extremity prostheses, flex foot system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5981	All lower extremity prostheses, flex-walk system or equal	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5982	All exoskeletal lower extremity prostheses, axial rotation unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6621	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7170	Electronic elbow, hosmer or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7185	Electronic elbow, adolescent, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7259	Electronic wrist rotator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L7360	Six volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7362	Battery charger, six volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7366	Battery charger, twelve volt, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7367	Lithium ion battery, rechargeable, replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2007	12/31/2999
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2009	12/31/2999
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/1/2007	12/31/2999
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2016	12/31/2999
L8609	ARTIFICIAL CORNEA	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2015	12/31/2999
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2014	12/31/2999
L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8679	Implantable neurostimulator, pulse generator, any type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8680	Implantable neurostimulator electrode, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8682	Implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/19/2022	12/31/2999
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2023	12/31/2999
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2018	12/31/2999
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/19/2022	12/31/2999
L8698	Miscellaneous component, supply or accessory for use with total artificial heart system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2019	12/31/2999
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
M0100	Intragastric hypothermia using gastric freezing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
M0300	Iv chelation therapy (chemical endarterectomy)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
M0301	Fabric wrapping of abdominal aneurysm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
P2029	Congo red, blood	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
P2031	Hair analysis (excluding arsenic)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
P9603	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
P9604	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge.	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
Q0035	Cardiokymography	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0490	Emergency power source for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2005	12/31/2999
Q0510	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH FOLLOWING transPLANT	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
Q0511	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
Q0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2006	12/31/2999
Q2026	INJECTION, RADIESSE, 0.1 ML	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2013	12/31/2999
Q2028	Injection, sculptra, 0.5 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2018	12/31/2999
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2011	12/31/2999
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2024	12/31/2999
Q2052	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2014	12/31/2999
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2021	12/31/2999
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2021	12/31/2999
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2022	12/31/2999
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4121	THERASKIN, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2021	12/31/2999
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2020	12/31/2999
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
Q4151	Amnioband or guardian, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2022	12/31/2999
Q4168	Amnioband, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4186	Epifix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2021	12/31/2999
Q4283	Biovance tri-layer or biovance 3l, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/15/2023	12/31/2999
Q4304	Grafix plus, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2024	12/31/2999
Q4334	Amnioplast 1, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4335	Amnioplast 2, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4336	Artacent c, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4337	Artacent trident, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4338	Artacent velos, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4339	Artacent vericlen, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4340	Simpligraft, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4341	Simplimax, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4342	Theramend, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4344	Tri-membrane wrap, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4345	Matrix hd allograft dermis, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	5/14/2025
Q4346	Shelter dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4347	Rampart dl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4348	Sentry sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4349	Mantle dl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4350	Palisade dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4351	Enclose tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4352	Overlay sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q4353	Xceed tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/15/2025	12/31/2999
Q5106	Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/15/2020	12/31/2999
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2020	12/31/2999
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	8/1/2024	12/31/2999
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/1/2024	12/31/2999
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/15/2025	12/31/2999
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	7/15/2024	12/31/2999
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2025	12/31/2999
S0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2021	12/31/2999
S0117	Tretinoin, topical, 5 grams	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0142	COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MG	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2005	12/31/2999
S0197	PRENATAL VITAMINS, 30-DAY SUPPLY	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	4/1/2005	12/31/2999
S0207	Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0209	Wheelchair van, mileage, per mile	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0215	Non-emergency transportation; mileage, per mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S0800	Laser in situ keratomileusis (lasik)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	11/1/2011	12/31/2999
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
S2102	Islet cell tissue transplant from pancreas; allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/15/2023	12/31/2999
S2103	Adrenal tissue transplant to brain	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
S2107	Adoptive immunotherapy i. E. Development of specific anti-tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2025	12/31/2999
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral components	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2008	12/31/2999
S2140	Cord blood harvesting for transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2142	Cord blood-derived stem-cell transplantation, allogeneic	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	2/1/2013	12/31/2999
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S2230	Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S2400	Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2402	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2012	12/31/2999
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2012	12/31/2999
S2409	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	12/1/2022	12/31/2999
S3600	Stat laboratory request (situations other than s3601)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S3601	Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4026	Procurement of donor sperm from sperm bank	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4027	Storage of previously frozen embryos	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4030	Sperm procurement and cryopreservation services; initial visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4031	Sperm procurement and cryopreservation services; subsequent visit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5101	Day care services, adult; per half day	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5102	Day care services, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5105	Day care services, center-based; services not included in program fee, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5109	Home care training to home care client, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5110	Home care training, family; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5111	Home care training, family; per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5115	Home care training, non-family; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5116	Home care training, non-family; per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5120	Chore services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5121	Chore services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5135	Companion care, adult (e. G. Iadl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5136	Companion care, adult (e. G. Iadl/adl); per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5162	Emergency response system; purchase only	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5165	Home modifications; per service	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5170	Home delivered meals, including preparation; per meal	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5175	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5185	Medication reminder service, non-face-to-face; per month	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S5199	Personal care item, nos, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S8035	Magnetic source imaging	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2009	12/31/2999
S8040	Topographic brain mapping	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3/1/2024	12/31/2999
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2005	12/31/2999
S8415	Supplies for home delivery of infant	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S8460	Camisole, post-mastectomy	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S8930	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	4/1/2024	12/31/2999
S9055	Procuren or other growth factor preparation to promote wound healing	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	11/1/2019	12/31/2999
S9117	Back school, per visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2022	12/31/2999
S9125	Respite care, in the home, per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9436	Childbirth preparation/lamaze classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9437	Childbirth refresher classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9438	Cesarean birth classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9439	Vbac (vaginal birth after cesarean) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9444	Parenting classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9447	Infant safety (including cpr) classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9449	Weight management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9451	Exercise classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9454	Stress management classes, non-physician provider, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2005	12/31/2999
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
S9900	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/2014	12/31/2999
S9970	Health club membership, annual	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9976	Lodging, per diem, not otherwise classified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9977	Meals, per diem, not otherwise specified	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9981	Medical records copying fee, administrative	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9982	Medical records copying fee, per page	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9986	Not medically necessary service (patient is aware that service not medically necessary)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9988	Services provided as part of a phase i clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9989	Services provided outside of the united states of america (list in addition to code(s) for services(s))	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9990	Services provided as part of a phase ii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9991	Services provided as part of a phase iii clinical trial	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9992	Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9994	Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9996	Meals for clinical trial participant and one caregiver/companion	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
S9999	Sales tax	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2025	Deluxe frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
V2219	Bifocal seg width over 28mm	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2600	Hand held low vision aids and other nonspectacle mounted aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2610	Single lens spectacle mounted low vision aids	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2627	Scleral cover shell	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	5/15/2016	12/31/2999
V2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
V2715	Prism, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2718	Press-on lens, fresnell prism, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2730	Special base curve, glass or plastic, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2744	Tint, photochromatic, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2750	Anti-reflective coating, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2755	U-v lens, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2760	Scratch resistant coating, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2770	Occluder lens, per lens	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	10/15/2008	12/31/2999
V2799	Vision item or service, miscellaneous	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
V5095	Semi-implantable middle ear hearing prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	1/1/1950	12/31/2999
V5364	Dysphagia screening	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
20561	Needle insertion(s) without injection(s); 3 or more muscles	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22526	Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2018
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22527	Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2018
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22867	Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2017	12/31/2018

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22868	Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2017	12/31/2018
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22869	Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; single level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2017	12/31/2018
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
22870	Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; second level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2017	12/31/2018
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	1/14/2025
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	1/14/2025
41530	Submucosal ablation of the tongue base radiofrequency 1 or more sites per session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	3/31/2024
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
53855	Insertion of a temporary prostatic urethral stent including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	10/14/2020
53855	Insertion of a temporary prostatic urethral stent including urethral measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	10/31/2019

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	1/31/2025
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
62287	Decompression procedure percutaneous of nucleus pulposus of intervertebral disc any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization with discography and/or epidural injection(s) at the treated level(s) when performed single or multiple levels lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/15/2016	10/31/2019
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
82523	Collagen cross links, any method	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/15/2014	12/31/2999
83695	Lipoprotein (a)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
83722	Lipoprotein, direct measurement; small dense LDL cholesterol	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
83987	pH; exhaled breath condensate	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
84112	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
93153	Interrogation without programming of implanted phrenic nerve stimulator system	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
94016	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
95919	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	7/1/2018	12/31/2999
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection discectomy facetectomy and/or foraminotomy) any method under indirect image guidance (eg fluoroscopic CT) single or multiple levels unilateral or bilateral; cervical or thoracic	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	2/15/2018	12/31/2018
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection discectomy facetectomy and/or foraminotomy) any method under indirect image guidance (eg fluoroscopic CT) single or multiple levels unilateral or bilateral; lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/15/2014	12/31/2018
0322U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
0335T	Insertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead sensing lead implantable pulse generator)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea pulse generator only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2023
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids including fitting training and insertion unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2022
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids including re-training and removal of existing insert unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2022
0499T	Cystourethroscopy with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis including fluoroscopy when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2023
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
0533T	Continuous recording of movement disorder symptoms including bradykinesia dyskinesia and tremor for 6 days up to 10 days; includes set-up patient training configuration of monitor data upload analysis and initial report configuration download review interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2023
0534T	Continuous recording of movement disorder symptoms including bradykinesia dyskinesia and tremor for 6 days up to 10 days; set-up patient training configuration of monitor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2023

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0535T	Continuous recording of movement disorder symptoms including bradykinesia dyskinesia and tremor for 6 days up to 10 days; data upload analysis and initial report configuration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2023
0536T	Continuous recording of movement disorder symptoms including bradykinesia dyskinesia and tremor for 6 days up to 10 days; download review interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2023
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
0615T	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0621T	Trabeculostomy ab interno by laser;	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries including right heart catheterization pulmonary artery angiography and all imaging guidance	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	6/30/2023

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2021	12/31/2999
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0641T	Noncontact near-infrared spectroscopy studies of flap or wound (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation [StO2]); image acquisition only each flap or wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2023
0642T	Noncontact near-infrared spectroscopy studies of flap or wound (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation [StO2]); interpretation and report only each flap or wound	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2023
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2021	12/31/2999
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0665T	Donor hysterectomy (including cold preservation); open, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse peripheral nerve subsequent treatment including noninvasive electroneurographic localization (nerve conduction localization) when performed; first nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2023
0769T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse peripheral nerve subsequent treatment including noninvasive electroneurographic localization (nerve conduction localization) when performed; each additional nerve (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2023
0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0775T	Arthrodesis sacroiliac joint percutaneous with image guidance includes placement of intra-articular implant(s) (eg bone allograft[s] synthetic device[s])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2023
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2023	12/31/2999
0809T	Arthrodesis sacroiliac joint percutaneous or minimally invasive (indirect visualization) with image guidance placement of transfixing device(s) and intraarticular implant(s) including allograft or synthetic device(s)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2023
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
A2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
A2012	Suprathel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
A2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
A2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999

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A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2024	Resolve matrix or xenopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
A2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
A2027	Matriderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A2028	Micromatrix flex, per mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A2029	Mirotract wound matrix sheet, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/15/2024	12/31/2999
A4596	Cranial electrotherapy stimulation (ces) system supplies and accessories, per month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2023	12/31/2999
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
A7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
A9285	Inversion/eversion correction device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
A9291	Prescription digital cognitive and/or behavioral therapy fda cleared per course of treatment	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	1/31/2024
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

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C1832	Autograft suspension, including cell processing and application, and all system components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
C9768	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
C9771	Nasal/sinus endoscopy cryoablation nasal tissue(s) and/or nerve(s) unilateral or bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2023
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2999
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0732	Cranial electrotherapy stimulation (ces) system, any type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
E0830	Ambulatory traction device, all types, each	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/15/2014	12/31/2999
E0840	Traction frame, attached to headboard, cervical traction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0850	Traction stand, free standing, cervical traction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0855	Cervical traction equipment not requiring additional stand or frame	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/15/2014	12/31/2999
E0856	Cervical traction device, with inflatable air bladder(s)	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0860	Traction equipment, overdoor, cervical	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0890	Traction frame, attached to footboard, pelvic traction	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0942	Cervical head harness/halter	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E0944	Pelvic belt/harness/boot	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	9/1/2020	12/31/2999
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
E3000	Speech volume modulation system, any type, including all components and accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	12/31/2999
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0460	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2022	12/31/2999
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
K1004	Low frequency ultrasonic diathermy treatment device for home use	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
K1009	Speech volume modulation system any type including all components and accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2023
K1018	External upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2023
K1019	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/15/2021	12/31/2023
K1024	Non-pneumatic compression controller with sequential calibrated gradient pressure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2022	6/30/2023
K1025	Non-pneumatic sequential compression garment full arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2022	6/30/2023
K1031	Non-pneumatic compression controller without calibrated gradient pressure	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	6/30/2023
K1032	Non-pneumatic sequential compression garment full leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	6/30/2023
K1033	Non-pneumatic sequential compression garment half leg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	6/30/2023

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
M0244	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	3/31/2025
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	3/31/2025
P9020	Platelet rich plasma, each unit	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0240	Injection, casirivimab and imdevimab, 600 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	1/31/2025
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	6/1/2023	3/31/2025
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4118	MATRISTEM MICROMATRIX, 1 MG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4121	THERASKIN PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	6/30/2024
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4127	TALYMED, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4134	Hmatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4135	Mediskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4136	Ez-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4137	Amnioexcel amnioexcel plus or biodexcel per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	7/31/2024

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4138	Biodfence dryflex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4140	Biodfence, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4141	Alloskin ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4142	Xcm biologic tissue matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4143	Repriza, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4145	Epifix, injectable, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4146	Tensix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4149	Excellagen, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4150	Allowrap ds or dry, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4153	Dermavest and plurivest, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2021	12/31/2999
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4177	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4178	Floweramniopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4179	Flowerderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

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Q4180	Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4181	Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4182	Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4183	Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4184	Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4188	Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4189	Artacent ac, 1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4190	Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4191	Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4192	Restorigin, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4193	Coll-e-derm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999

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Q4194	Novachor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4195	Puraply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4196	Puraply am, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4197	Puraply xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4198	Genesis amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4199	Cygnus matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4200	Skin te, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4201	Matrion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4202	Keroxx (2.5g/cc), 1cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4203	Derma-gide, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4204	Xwrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4205	Membrane graft or membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4206	Fluid flow or fluid GF, 1 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4208	Novafix, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4209	Surgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4210	Axolotl graft or axolotl dualgraft per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	6/30/2024
Q4211	Amnion bio or Axobiomembrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4212	Allogen, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4213	Ascent, 0.5 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4214	Cellesta cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4216	Artacent cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4218	Surgicord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4219	Surgigraft-dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4220	BellaCell HD or Surederm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4221	Amniowrap2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4222	Progenamatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2021	12/31/2999
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
Q4225	Amniobind or dermabind tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
Q4226	MyOwn skin, includes harvesting and preparation procedures, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2024	12/31/2999
Q4227	Amniocore, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4229	Cogenex amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4230	Cogenex flowable amnion, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4231	Corplex p, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	3/31/2025
Q4232	Corplex, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4233	Surfactor or nudyn, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4234	Xcellerate, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4235	Amniorepair or altiply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4236	Carepatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4237	Cryo-cord, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4238	Derm-maxx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2022	12/31/2999
Q4239	Amnio-maxx or amnio-maxx lite, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4240	Corecyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4241	Polycyte, for topical use only, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4242	Amniocyte plus, per 0.5 cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4244	Procenta per 200 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	3/31/2024
Q4245	Amniotext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4246	Coretext or protext, per cc	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4247	Amniotext patch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4248	Dermacyte amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
Q4249	Amniply, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4250	Amnioamp-mp, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4251	Vim, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4252	Vendaje, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4253	Zenith amniotic membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/15/2022	12/31/2999
Q4254	Novafix dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4255	Reguard, for topical use only, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3/1/2021	12/31/2999
Q4256	Mlg-complete, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
Q4257	Relese, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	8/1/2022	12/31/2999
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4262	Dual layer impax membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4263	Surgraft tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	1/1/2023	12/31/2999
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2023	12/31/2999
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4277	Woundplus membrane or e-graft per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	6/30/2024
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4282	Cygnus dual, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4284	Dermabind sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2023	12/31/2999
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4286	Nudyn sl or nudyn slw, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	10/1/2023	12/31/2999
Q4287	Dermabind dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4288	Dermabind ch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4289	Revoshield + amniotic barrier, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4290	Membrane wrap-hydro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4291	Lamellas xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4292	Lamellas, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4293	Acesso dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4294	Amnio quad-core, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4295	Amnio tri-core amniotic, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4301	Activate matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4306	American amnion ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4307	American amnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999

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Q4308	Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4309	Via matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4310	Procenta, per 100 mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	12/31/2999
Q4311	Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4312	Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4313	Dermabind fm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4314	Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4315	Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4316	Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4317	Vitograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4318	E-graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4319	Sanograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4320	Pellograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4321	Renograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4322	Caregraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4323	Alloply, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4324	Amniotx, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4325	Acapatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4326	Woundplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4327	Duoamnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4328	Most, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4329	Singlay, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4330	Total, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4331	Axolotl graft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	12/31/2999
Q4334	Amnioplast 1, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4335	Amnioplast 2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4336	Artacent c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4337	Artacent trident, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4338	Artacent velos, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4339	Artacent vericlen, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4340	Simpligraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4341	Simplimax, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4342	Theramend, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4344	Tri-membrane wrap, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
Q4345	Matrix hd allograft dermis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2025	12/31/2999
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S3650	Saliva test, hormone level; during menopause	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S3652	Saliva test, hormone level; to assess preterm labor risk	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	9/1/2020	12/31/2999
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	12/1/2020	12/31/2999
S9090	Vertebral axial decompression, per session	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	12/15/2014	12/31/2999
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0380	BLS mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0382	Basic Life Support (BLS) routine disposable supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS (Advanced Life Support) ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0390	ALS mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0394	ALS specialized service disposable supplies; IV drug therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0396	ALS specialized service disposable supplies; esophageal intubation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0398	ALS routine disposable supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour increments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0425	Ground mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0426	Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0433	Advanced life support, Level 2 (ALS2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0434	Specialty care transport (SCT)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0998	Ambulance response and treatment, no transport	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999

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

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 Texas.

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

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