

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.
	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.
	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	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	guidance; total leiomyomata volume less than 200 cc of tissue	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	guidance; total leiomyomata volume greater or equal to 200 cc of tissue	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	444540000	10/04/0000
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including		11/15/2006	12/31/2999
	radiologic supervision and interpretation, open or percutaneous; each	Medical Policy Criteria. Submit for Recommended		
	additional vessel (List separately in addition to code for primary	Clinical Review to avoid post-service review.		
0.40=1.1	procedure)		10///0004	5// //0005
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent	MP Criteria: Procedure/service reviewed against	10/1/2024	5/14/2025
	immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor	Medical Policy Criteria. Submit for Recommended		
	superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1)	Clinical Review to avoid post-service review.		
	combined with longitudinal clinical data, including APOL1 genotype if			
	available, and plasma (isolated fresh or frozen), algorithm reported as			
00007	probability score for rapid kidney function decline (RKFD)	MD Oritoria December 1 and a constitution of a constitution	44/4/0040	40/04/0000
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s),	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	including the use of a balloon or mechanical device, when used, 1 or	Medical Policy Criteria. Submit for Recommended		
	more needles, includes imaging guidance and bone biopsy, when	Clinical Review to avoid post-service review.		
0201T	performed Percutaneous sacral augmentation (sacroplasty), bilateral injections,	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
02011			11/1/2019	12/31/2999
	including the use of a balloon or mechanical device, when used, 2 or	Medical Policy Criteria. Submit for Recommended		
	more needles, includes imaging guidance and bone biopsy, when	Clinical Review to avoid post-service review.		
0253T	performed Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
02331	extraocular reservoir, internal approach, into the suprachoroidal space	Medical Policy Criteria. Submit for Recommended	1/1/2011	12/31/2999
	extraocular reservoir, internar approach, into the suprachoroldar space	Clinical Review to avoid post-service review.		
0266T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
02001	total system (includes generator placement, unilateral or bilateral lead	Medical Policy Criteria. Submit for Recommended	10/1/2022	12/01/2000
	placement, intra-operative interrogation, programming, and repositioning,	Clinical Review to avoid post-service review.		
	when performed)	official review to avoid post-service review.		
0267T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
02011	lead only, unilateral (includes intra-operative interrogation, programming,	Medical Policy Criteria. Submit for Recommended	10/1/2022	12/01/2000
	and repositioning, when performed)	Clinical Review to avoid post-service review.		
0268T	Implantation or replacement of carotid sinus baroreflex activation device;	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	pulse generator only (includes intra-operative interrogation, programming,	Medical Policy Criteria. Submit for Recommended		
	and repositioning, when performed)	Clinical Review to avoid post-service review.		
0269T	Revision or removal of carotid sinus baroreflex activation device; total	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	system (includes generator placement, unilateral or bilateral lead	Medical Policy Criteria. Submit for Recommended		
	placement, intra-operative interrogation, programming, and repositioning,	Clinical Review to avoid post-service review.		
	when performed)			
0270T	Revision or removal of carotid sinus baroreflex activation device; lead	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	only, unilateral (includes intra-operative interrogation, programming, and	Medical Policy Criteria. Submit for Recommended		
	repositioning, when performed)	Clinical Review to avoid post-service review.		
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	generator only (includes intra-operative interrogation, programming, and	Medical Policy Criteria. Submit for Recommended		
	repositioning, when performed)	Clinical Review to avoid post-service review.		

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 lgG 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		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	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/15/2024	12/31/2999
	programming of sensing and therapeutic parameters; pulse generator	Clinical Review to avoid post-service review.		
	only	Cillical Review to avoid post-service review.		
0410T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
J4 10 1	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended	3/13/2024	12/31/2999
	programming of sensing and therapeutic parameters; atrial electrode only			
	programming or sensing and therapeutic parameters, athar electrode only	Cliffical Neview to avoid post-service review.		
0411T	Insertion or replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system, including contractility evaluation when performed, and	Medical Policy Criteria. Submit for Recommended		
	programming of sensing and therapeutic parameters; ventricular electrode	Clinical Review to avoid post-service review.		
	only	'		
0412T	Removal of permanent cardiac contractility modulation system; pulse	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	generator only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0413T	Removal of permanent cardiac contractility modulation system;	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	transvenous electrode (atrial or ventricular)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0414T	Removal and replacement of permanent cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	system pulse generator only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0415T	Repositioning of previously implanted cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	transvenous electrode (atrial or ventricular lead)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0416T	Relocation of skin pocket for implanted cardiac contractility modulation	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	pulse generator	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0417T	Programming device evaluation (in person) with iterative adjustment of	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	the implantable device to test the function of the device and select optimal			
	permanent programmed values with analysis, including review and report,	Clinical Review to avoid post-service review.		
	implantable cardiac contractility modulation system			
0418T	Interrogation device evaluation (in person) with analysis, review and	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	report, includes connection, recording and disconnection per patient	Medical Policy Criteria. Submit for Recommended		
	encounter, implantable cardiac contractility modulation system	Clinical Review to avoid post-service review.		
)422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	bilateral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	extremity distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		10/04/0000
)441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	extremity distal/peripheral nerve	Medical Policy Criteria. Submit for Recommended		
2440		Clinical Review to avoid post-service review.	5/4/0004	10/04/0000
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Medical Policy Criteria. Submit for Recommended		
2440T	Uncoding of a managed decision and a control of the	Clinical Review to avoid post-service review.	4/4/0000	40/04/0000
0449T	Insertion of aqueous drainage device, without extraocular reservoir,	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	internal approach, into the subconjunctival space; initial device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		1

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0450T	Insertion of aqueous drainage device, without extraocular reservoir,	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	internal approach, into the subconjunctival space; each additional device	Medical Policy Criteria. Submit for Recommended		
	(List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
0474T	Insertion of anterior segment aqueous drainage device, with creation of	MP Criteria: Procedure/service reviewed against	7/1/2017	12/31/2999
	intraocular reservoir, internal approach, into the supraciliary space	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0494T	Surgical preparation and cannulation of marginal (extended) cadaver	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	donor lung(s) to ex vivo organ perfusion system, including decannulation,	Medical Policy Criteria. Submit for Recommended		
	separation from the perfusion system, and cold preservation of the	Clinical Review to avoid post-service review.		
	allograft prior to implantation, when performed	i i		
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	perfusion system by physician or qualified health care professional,	Medical Policy Criteria. Submit for Recommended		
	including physiological and laboratory assessment (eg, pulmonary artery	Clinical Review to avoid post-service review.		
	flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular	i '		
	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			
)496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	perfusion system by physician or qualified health care professional,	Medical Policy Criteria. Submit for Recommended		
	including physiological and laboratory assessment (eg, pulmonary artery	Clinical Review to avoid post-service review.		
	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)			
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
	device interrogation and programming, and imaging supervision and	Medical Policy Criteria. Submit for Recommended	1.07.1720.10	1.2/01/2000
	interpretation, when performed; electrode only	Clinical Review to avoid post-service review.		
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including		10/1/2019	12/31/2999
	device interrogation and programming, and imaging supervision and	Medical Policy Criteria. Submit for Recommended	1.07.1720.10	1.270.172000
	interpretation, when performed; both components of pulse generator	Clinical Review to avoid post-service review.		
	(battery and transmitter) only	Olimbar Noview to avoid post service review.		
)524T	Endovenous catheter directed chemical ablation with balloon isolation of	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
70211	incompetent extremity vein, open or percutaneous, including all vascular	Medical Policy Criteria. Submit for Recommended	10/1/2010	12/01/2000
	access, catheter manipulation, diagnostic imaging, imaging guidance and	Clinical Review to avoid post-service review.		
	monitoring	Official Neview to avoid post-service review.		
)529T	Interrogation device evaluation (in person) of intracardiac ischemia	MP Criteria: Procedure/service reviewed against	10/1/2019	12/31/2999
30201	monitoring system with analysis, review, and report	Medical Policy Criteria. Submit for Recommended	10/1/2010	12/01/2000
	monitoring system with analysis, leview, and report	Clinical Review to avoid post-service review.		
D544T	Transcatheter mitral valve annulus reconstruction, with implantation of	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
OOTT 1	adjustable annulus reconstruction device, percutaneous approach	Medical Policy Criteria. Submit for Recommended	10/1/2022	12,01/2000
	including transseptal puncture	Clinical Review to avoid post-service review.		1
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
JJ7-J I	adjustable annulus reconstruction device, percutaneous approach	Medical Policy Criteria. Submit for Recommended	31 112023	12/3//2399
	aujustable annulus reconstruction device, percutaneous approach	•		1
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic	MP Criteria: Procedure/service reviewed against	12/15/2020	12/31/2999
	energies, provided by a physician or other qualified health care	Medical Policy Criteria. Submit for Recommended		
	professional	Clinical Review to avoid post-service review.		
0561T	Anatomic guide 3D-printed and designed from image data set(s); first	MP Criteria: Procedure/service reviewed against	11/1/2024	12/31/2999
	anatomic guide	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0562T	Anatomic guide 3D-printed and designed from image data set(s); each	MP Criteria: Procedure/service reviewed against	11/1/2024	12/31/2999
	additional anatomic guide (List separately in addition to code for primary	Medical Policy Criteria. Submit for Recommended		
	procedure)	Clinical Review to avoid post-service review.		
0571T	Insertion or replacement of implantable cardioverter-defibrillator system	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	with substernal electrode(s), including all imaging guidance and	Medical Policy Criteria. Submit for Recommended		
	electrophysiological evaluation (includes defibrillation threshold	Clinical Review to avoid post-service review.		
	evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia	· ·		
	termination, and programming or reprogramming of sensing or			
	therapeutic parameters), when performed			
0572T	Insertion of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	· ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0573T	Removal of substernal implantable defibrillator electrode	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0574T	Repositioning of previously implanted substernal implantable defibrillator-	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	pacing electrode	Medical Policy Criteria. Submit for Recommended		12/01/2000
	pasing sissards	Clinical Review to avoid post-service review.		
0575T	Programming device evaluation (in person) of implantable cardioverter-	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
00101	defibrillator system with substernal electrode, with iterative adjustment of	Medical Policy Criteria. Submit for Recommended	2,10,2020	12/01/2000
	the implantable device to test the function of the device and select optimal	,		
	permanent programmed values with analysis, review and report by a	Chillion Review to avoid post service review.		
	physician or other qualified health care professional			
0576T	Interrogation device evaluation (in person) of implantable cardioverter-	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
00701	defibrillator system with substernal electrode, with analysis, review and	Medical Policy Criteria. Submit for Recommended	2/10/2020	12/01/2000
	report by a physician or other qualified health care professional, includes	Clinical Review to avoid post-service review.		
	connection, recording and disconnection per patient encounter	Cililical Neview to avoid post-service review.		
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
03771	system with substernal electrode (includes defibrillation threshold	Medical Policy Criteria. Submit for Recommended	2/13/2023	12/31/2999
		Clinical Review to avoid post-service review.		
	evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia	Clinical Review to avoid post-service review.		
	termination, and programming or reprogramming of sensing or			
0578T	therapeutic parameters) Interrogation device evaluation(s) (remote), up to 90 days, substernal lead	MD Criteria: Precedure/corvice reviewed against	2/15/2025	12/31/2999
J3/01		•	2/15/2025	12/31/2999
	implantable cardioverter-defibrillator system with interim analysis,	Medical Policy Criteria. Submit for Recommended		
	review(s) and report(s) by a physician or other qualified health care	Clinical Review to avoid post-service review.		
0570T	professional Interrogation device evaluation(s) (remote), up to 90 days, substernal lead	MD Critorio: Propoduro/pomico maximum de accident	2/15/2025	12/21/2000
0579T			2/15/2025	12/31/2999
	implantable cardioverter-defibrillator system, remote data acquisition(s),	Medical Policy Criteria. Submit for Recommended		1
	receipt of transmissions and technician review, technical support and	Clinical Review to avoid post-service review.		
0500T	distribution of results	MD 0 ii i D	0/45/0005	40/04/0000
0580T	Removal of substernal implantable defibrillator pulse generator only	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0587T	Percutaneous implantation or replacement of integrated single device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction including electrode array	Medical Policy Criteria. Submit for Recommended		
	and receiver or pulse generator, including analysis, programming, and	Clinical Review to avoid post-service review.		
	imaging guidance when performed, posterior tibial nerve			
0588T	Revision or removal of percutaneously placed integrated single device	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction including electrode array	Medical Policy Criteria. Submit for Recommended		
	and receiver or pulse generator, including analysis, programming, and	Clinical Review to avoid post-service review.		
	imaging guidance when performed, posterior tibial nerve			
0589T	Electronic analysis with simple programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction (eg, electrode array and	Medical Policy Criteria. Submit for Recommended		
	receiver), including contact group(s), amplitude, pulse width, frequency	Clinical Review to avoid post-service review.		
	(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			
2500	parameters	MD O II I D	0/4/0004	40/04/0000
0590T	Electronic analysis with complex programming of implanted integrated	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	neurostimulation system for bladder dysfunction (eg, electrode array and	Medical Policy Criteria. Submit for Recommended		
	receiver), including contact group(s), amplitude, pulse width, frequency	Clinical Review to avoid post-service review.		
	(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			
0596T	parameters Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial	MD Criteria: Precedure/corvice reviewed against	11/15/2023	12/31/2999
03901	insertion, including urethral measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	11/15/2023	12/31/2999
		Clinical Review to avoid post-service review.		
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis);	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
00371	replacement	Medical Policy Criteria. Submit for Recommended	11/13/2023	12/51/2999
	replacement	Clinical Review to avoid post-service review.		
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ,	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
J000 I	including imaging guidance, when performed, percutaneous	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
	moduling imaging guidance, when performed, performeds	Clinical Review to avoid post-service review.		
0601T	Ablation, irreversible electroporation; 1 or more tumors per organ,	MP Criteria: Procedure/service reviewed against	9/1/2023	12/31/2999
00011	including fluoroscopic and ultrasound guidance, when performed, open	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
	molading hadrosopic and distassanta galadines, which performed, open	Clinical Review to avoid post-service review.		
0614T	Removal and replacement of substernal implantable defibrillator pulse	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	generator	Medical Policy Criteria. Submit for Recommended		
	3	Clinical Review to avoid post-service review.		
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
	pulmonary arteries, including right heart catheterization, pulmonary artery	Medical Policy Criteria. Submit for Recommended		
	angiography, and all imaging guidance	Clinical Review to avoid post-service review.		
0643T	Transcatheter left ventricular restoration device implantation including	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	right and left heart catheterization and left ventriculography when	Medical Policy Criteria. Submit for Recommended		
	performed, arterial approach	Clinical Review to avoid post-service review.		
0645T	Transcatheter implantation of coronary sinus reduction device including	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
	vascular access and closure, right heart catheterization, venous	Medical Policy Criteria. Submit for Recommended		
	angiography, coronary sinus angiography, imaging guidance, and	Clinical Review to avoid post-service review.		
	supervision and interpretation, when performed	· ·		1

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	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
	values with analysis, review and report by a physician or other qualified health care professional	Cliffical Review to avoid post-service review.		
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	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	interpretation 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
0789Т	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)		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 atria pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)		7/1/2023	12/31/2999
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	· ·	7/1/2023	12/31/2999
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
0799Т	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)	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,	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	right atrial, including imaging guidance (eg, fluoroscopy, venous	Medical Policy Criteria. Submit for Recommended		
	ultrasound, right atrial angiography and/or right ventriculography, femoral	Clinical Review to avoid post-service review.		
	venography, cavography), when performed			
0825T	Transcatheter removal and replacement of permanent single-chamber	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	leadless pacemaker, right atrial, including imaging guidance (eg,	Medical Policy Criteria. Submit for Recommended		
	fluoroscopy, venous ultrasound, right atrial angiography and/or right	Clinical Review to avoid post-service review.		
	ventriculography, femoral venography, cavography) and device evaluation			
	(eg, interrogation or programming), when performed			
0826T	Programming device evaluation (in person) with iterative adjustment of	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
	the implantable device to test the function of the device and select optimal	Medical Policy Criteria. Submit for Recommended		
	permanent programmed values with analysis, review and report by a	Clinical Review to avoid post-service review.		
	physician or other qualified health care professional, leadless pacemaker			
	system in single-cardiac chamber			
)861T	Removal of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	ventricular pacing; both components (battery and transmitter)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0862T	Relocation of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	ventricular pacing, including device interrogation and programming;	Medical Policy Criteria. Submit for Recommended		
	battery component only	Clinical Review to avoid post-service review.		
0863T	Relocation of pulse generator for wireless cardiac stimulator for left	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	ventricular pacing, including device interrogation and programming;	Medical Policy Criteria. Submit for Recommended		
	transmitter component only	Clinical Review to avoid post-service review.		
0868T	High-resolution gastric electrophysiology mapping with simultaneous	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	patientsymptom profiling, with interpretation and report	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0870T	Implantation of subcutaneous peritoneal ascites pump system,	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	percutaneous, including pump-pocket creation, insertion of tunneled	Medical Policy Criteria. Submit for Recommended		
	indwelling bladder and peritoneal catheters with pump connections,	Clinical Review to avoid post-service review.		
	including all imaging and initial programming, when performed	· ·		
0871T	Replacement of a subcutaneous peritoneal ascites pump, including	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	reconnection between pump and indwelling bladder and peritoneal	Medical Policy Criteria. Submit for Recommended		
	catheters, including initial programming and imaging, when performed	Clinical Review to avoid post-service review.		
0872T	Replacement of indwelling bladder and peritoneal catheters, including	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	tunneling of catheter(s) and connection with previously implanted	Medical Policy Criteria. Submit for Recommended		
	peritoneal ascites pump, including imaging and programming, when	Clinical Review to avoid post-service review.		
	performed	· ·		
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system,	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	any component (ascites pump, associated peritoneal catheter, associated	Medical Policy Criteria. Submit for Recommended		
	bladder catheter), including imaging and programming, when performed	Clinical Review to avoid post-service review.		
		·		
0874T	Removal of a peritoneal ascites pump system, including implanted	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	peritoneal ascites pump and indwelling bladder and peritoneal catheters	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0875T	Programming of subcutaneously implanted peritoneal ascites pump	MP Criteria: Procedure/service reviewed against	9/1/2024	5/14/2025
	system by physician or other qualified health care professional	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15271	Application of skin substitute graft to trunk, arms, legs, total wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15272	Application of skin substitute graft to trunk, arms, legs, total wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	surface area up to 100 sq cm; each additional 25 sq cm wound surface	Medical Policy Criteria. Submit for Recommended		
	area, or part thereof (List separately in addition to code for primary	Clinical Review to avoid post-service review.		
	procedure)			
15273	Application of skin substitute graft to trunk, arms, legs, total wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	surface area greater than or equal to 100 sq cm; first 100 sq cm wound	Medical Policy Criteria. Submit for Recommended		
	surface area, or 1% of body area of infants and children	Clinical Review to avoid post-service review.		
15274	Application of skin substitute graft to trunk, arms, legs, total wound	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	surface area greater than or equal to 100 sq cm; each additional 100 sq	Medical Policy Criteria. Submit for Recommended		
	cm wound surface area, or part thereof, or each additional 1% of body	Clinical Review to avoid post-service review.		
	area of infants and children, or part thereof (List separately in addition to	·		
	code for primary procedure)			
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Clinical Review to avoid post-service review.		
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area up to 100 sq cm; each additional 25 sq cm wound surface	Clinical Review to avoid post-service review.		
	area, or part thereof (List separately in addition to code for primary			
	procedure)			
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area greater than or equal to 100 sq cm; first 100 sq cm wound	Clinical Review to avoid post-service review.		
	surface area, or 1% of body area of infants and children			
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound	Medical Policy Criteria. Submit for Recommended		
	surface area greater than or equal to 100 sq cm; each additional 100 sq	Clinical Review to avoid post-service review.		
	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)			
15758	Free fascial flap with microvascular anastomosis	MP Criteria: Procedure/service reviewed against	11/15/2010	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
	fat, dermis, fascia)	Medical Policy Criteria. Submit for Recommended	.,	.2,0.,2000
		Clinical Review to avoid post-service review.		
15771	Grafting of autologous fat harvested by liposuction technique to trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
10111	breasts, scalp, arms, and/or legs; 50 cc or less injectate	Medical Policy Criteria. Submit for Recommended	17 10/2021	12/01/2000
	broadto, soaip, arms, ana/or rogs, oo so or ross injectate	Clinical Review to avoid post-service review.		
15772	Grafting of autologous fat harvested by liposuction technique to trunk,	MP Criteria: Procedure/service reviewed against	1/15/2021	12/31/2999
10112	breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part	Medical Policy Criteria. Submit for Recommended	1, 10,2021	.2,01,2000
	thereof (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.	1	
15775	Punch graft for hair transplant; 1 to 15 punch grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10110	i unon grantior nan transplant, i to 15 punion grants	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/3//2399
		1	1	
		Clinical Review to avoid post-service review.	<u> </u>	

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	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids,	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	general keratosis)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15781	Dermabrasion; segmental, face	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15782	Dermabrasion; regional, other than face	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15786	Abrasion; single lesion (eg, keratosis, scar)	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	, 3 (3, , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15787	Abrasion; each additional 4 lesions or less (List separately in addition to	MP Criteria: Procedure/service reviewed against	8/1/2005	12/31/2999
	code for primary procedure)	Medical Policy Criteria. Submit for Recommended	07.172000	.2,0.,,2000
	bodo for primary procedure)	Clinical Review to avoid post-service review.		
15788	Chemical peel, facial; epidermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
.0.00	onomical pool, lastal, optionial	Medical Policy Criteria. Submit for Recommended	., .,	.2,0.,,2000
		Clinical Review to avoid post-service review.		
15789	Chemical peel, facial; dermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
10100	Onomical pool, radial, dormal	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
15792	Chemical peel, nonfacial; epidermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
10702	onomical pool, nomacial, opidermal	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
15793	Chemical peel, nonfacial; dermal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
10700	Onomical pool, nomicolal, domical	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
15820	Blepharoplasty, lower eyelid;	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
13020	biephalopiasty, lower eyellu,	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
13021	Diephalopiasty, lower eyellu, with extensive hernlated fat pad	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/31/2999
		Clinical Review to avoid post-service review.		
15822	Blepharoplasty, upper eyelid;	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
13022	biepharopiasty, upper eyenu,	•	1/1/1930	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/1950	12/21/2000
10023	Diepharopiasty, upper eyeliu, with excessive skin weighting down lid	•	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
45005	Di ci () () () () () () () () () (Clinical Review to avoid post-service review.	0/04/0040	10/04/0000
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15828	Rhytidectomy; cheek, chin, and neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	abdomen, infraumbilical panniculectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	thigh	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	leg	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	1-9	Clinical Review to avoid post-service review.		
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10001	hip	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	12/01/2000
	l"P	Clinical Review to avoid post-service review.		
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
10000	buttock	Medical Policy Criteria. Submit for Recommended	5/24/2012	12/01/2000
	buttock	Clinical Review to avoid post-service review.		
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
19090	arm	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/31/2999
	ann	Clinical Review to avoid post-service review.		
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
13637	forearm or hand	Medical Policy Criteria. Submit for Recommended	9/24/2012	12/31/2999
	lorearm or nand	1		
45000	Evolution associate ability and substitution as the state of the state	Clinical Review to avoid post-service review.	9/24/2012	12/31/2999
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	submental fat pad	Medical Policy Criteria. Submit for Recommended		
45000	Fortisting control the section of the fortist of th	Clinical Review to avoid post-service review.	0/04/0040	40/04/0000
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy);	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	other area	Medical Policy Criteria. Submit for Recommended		
15017		Clinical Review to avoid post-service review.	4/4/0007	40/04/0000
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy),	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	abdomen (eg, abdominoplasty) (includes umbilical transposition and	Medical Policy Criteria. Submit for Recommended		
	fascial plication) (List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
15876	Suction assisted lipectomy; head and neck	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
15076	Suction assisted lipectorny, nead and neck	_	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
45077	Constitute and interest the second of	Clinical Review to avoid post-service review.	0/04/0040	12/31/2999
15877	Suction assisted lipectomy; trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
45070	Out the second of the different control of the second of t	Clinical Review to avoid post-service review.	0/04/0040	40/04/0000
15878	Suction assisted lipectomy; upper extremity	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
45050		Clinical Review to avoid post-service review.	0/04/0046	10/01/005
15879	Suction assisted lipectomy; lower extremity	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	I.	Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	technique); less than 10 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	technique); 10.0 to 50.0 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	technique); over 50.0 sq cm	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17360	Chemical exfoliation for acne (eg, acne paste, acid)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
17380	Electrolysis epilation, each 30 minutes	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	each fibroadenoma	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19300	Mastectomy for gynecomastia	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	, 3,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19303	Mastectomy, simple, complete	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19318	Breast reduction	MP Criteria: Procedure/service reviewed against	6/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19325	Breast augmentation with implant	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	.=,0.,,=000
		Clinical Review to avoid post-service review.		
19328	Removal of intact breast implant	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
.0020	The state of the s	Medical Policy Criteria. Submit for Recommended	., .,	.=,0.,,=000
		Clinical Review to avoid post-service review.		
19330	Removal of ruptured breast implant, including implant contents (eg,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	saline, silicone gel)	Medical Policy Criteria. Submit for Recommended	., .,	.=, 0 ., = 000
	camile, emeche gery	Clinical Review to avoid post-service review.		
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
10010	incorder of prodet implant on came day of mactocomy (ic, immediate)	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
19342	Insertion or replacement of breast implant on separate day from	MP Criteria: Procedure/service reviewed against	7/1/2005	12/31/2999
10042	mastectomy	Medical Policy Criteria. Submit for Recommended	17172000	12/01/2000
	Inductioning	Clinical Review to avoid post-service review.		
19350	Nipple/areola reconstruction	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
19000	Γιηρρισται σοια Τσουποτι αστίστη	Medical Policy Criteria. Submit for Recommended	0/ 1/20 1/	12/3/1/2999
		Clinical Review to avoid post-service review.		
19355	Correction of inverted ninnles	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
18000	Correction of inverted nipples	•	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	<u> </u>	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19357	Tissue expander placement in breast reconstruction, including	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
	subsequent expansion(s)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19370	Revision of peri-implant capsule, breast, including capsulotomy,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	capsulorrhaphy, and/or partial capsulectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19371	Peri-implant capsulectomy, breast, complete, including removal of all	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	intracapsular contents	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
19499	Unlisted procedure, breast	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
	(eg, metastasis) including adjacent soft tissue when involved by tumor	Medical Policy Criteria. Submit for Recommended		
	extension, percutaneous, including imaging guidance when performed;	Clinical Review to avoid post-service review.		
	radiofrequency	·		
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	(eg, metastasis) including adjacent soft tissue when involved by tumor	Medical Policy Criteria. Submit for Recommended		
	extension, percutaneous, including imaging guidance when performed;	Clinical Review to avoid post-service review.		
	cryoablation	'		
21032	Excision of maxillary torus palatinus	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, '	Plan. Not subject to pre-service review.		
21083	Impression and custom preparation; palatal lift prosthesis	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21121	Genioplasty; sliding osteotomy, single piece	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	3 7 3 1	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	excision or bone wedge reversal for asymmetrical chin)	Medical Policy Criteria. Submit for Recommended		
	one of a some meage reversal reliancy mineral and many	Clinical Review to avoid post-service review.		
1123	Genioplasty; sliding, augmentation with interpositional bone grafts	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	(includes obtaining autografts)	Medical Policy Criteria. Submit for Recommended	072 1720 12	.2,0.,2000
	(molaudo dataminig datogranto)	Clinical Review to avoid post-service review.		
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	mandibular staple bone plate)	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	mandibular staple softe plate)	Clinical Review to avoid post-service review.		
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
0	. 185558 addition of manuality of maxima, outperfection implant, partial	Medical Policy Criteria. Submit for Recommended	., ,, ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.2,01,2000
		Clinical Review to avoid post-service review.		
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
. 1470	n coonstruction of manufactor maxifia, supperiosteal implant, complete	Medical Policy Criteria. Submit for Recommended	1/1/1830	12/01/2000
		•		
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade,	Clinical Review to avoid post-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
.1240	· · · · · ·		1/1/1950	12/31/2999
	cylinder); partial	Plan. Not subject to pre-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	cylinder); complete	Plan. Not subject to pre-service review.		
21685	Hyoid myotomy and suspension	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
23929	Unlisted procedure, shoulder	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27299	Unlisted procedure, pelvis or hip joint	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27702	Arthroplasty, ankle; with implant (total ankle)	MP Criteria: Procedure/service reviewed against	12/15/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
27703	Arthroplasty, ankle; revision, total ankle	MP Criteria: Procedure/service reviewed against	5/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(chondroplasty), abrasion arthroplasty, and/or resection of labrum	Medical Policy Criteria. Submit for Recommended	., .,	.2,0.,2000
	(orionaropiasty), abrasion artificiplasty, ana/or resession or labram	Clinical Review to avoid post-service review.		
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty)		1/1/2005	12/31/2999
20000	(includes harvesting of the autograft[s])	Medical Policy Criteria. Submit for Recommended	17 172000	12/01/2000
	(includes harvesting of the autografits)	Clinical Review to avoid post-service review.		
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	MP Criteria: Procedure/service reviewed against	8/15/2007	12/31/2999
23001	Antihoscopy, knee, surgical, osteochondral allogialt (og. mosaloplasty)	Medical Policy Criteria. Submit for Recommended	0/13/2007	12/01/2000
		Clinical Review to avoid post-service review.		
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy		1/1/2022	12/31/2999
29000	for meniscal insertion), medial or lateral	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
	nor meniscar insertion), mediai or lateral	1		
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
29914	Artifioscopy, hip, surgical, with remotoplasty (ie, treatment of call lesion)	Medical Policy Criteria. Submit for Recommended	1/1/2011	12/31/2999
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
29910		•	1/1/2011	12/31/2999
	lesion)	Medical Policy Criteria. Submit for Recommended		
29916	Arthroscopy, hip, surgical; with labral repair	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2011	12/31/2999
29910	Artifloscopy, hip, surgical, with labral repair	-	1/1/2011	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
20000	Unlinked anneading authoropout	Clinical Review to avoid post-service review.	11/1/2017	40/04/0000
29999	Unlisted procedure, arthroscopy	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
04047	Describe a service which are flexible to be for the original and the service are the service and the service are the service and the service are the service a	Clinical Review to avoid post-service review.	44/4/0040	40/04/0000
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	performed; with balloon occlusion, when performed, assessment of air	Medical Policy Criteria. Submit for Recommended		
0.10.10	leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Clinical Review to avoid post-service review.	111110010	10/01/0055
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	performed; with removal of bronchial valve(s), initial lobe	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	performed; with removal of bronchial valve(s), each additional lobe (List	Medical Policy Criteria. Submit for Recommended		
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	performed; with balloon occlusion, when performed, assessment of air	Medical Policy Criteria. Submit for Recommended		
	leak, airway sizing, and insertion of bronchial valve(s), each additional	Clinical Review to avoid post-service review.		
	lobe (List separately in addition to code for primary procedure[s])			
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	1/1/2013	5/14/2025
	performed; with bronchial thermoplasty, 1 lobe	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when	MP Criteria: Procedure/service reviewed against	1/1/2013	5/14/2025
	performed; with bronchial thermoplasty, 2 or more lobes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	tumor(s) including pleura or chest wall when involved by tumor extension,	Medical Policy Criteria. Submit for Recommended		
	percutaneous, including imaging guidance when performed, unilateral;	Clinical Review to avoid post-service review.		
	cryoablation	,		
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary	MP Criteria: Procedure/service reviewed against	6/1/2007	12/31/2999
	tumor(s) including pleura or chest wall when involved by tumor extension,	Medical Policy Criteria. Submit for Recommended		
	percutaneous, including imaging guidance when performed, unilateral;	Clinical Review to avoid post-service review.		
	radiofrequency	l '		
33211	Insertion or replacement of temporary transvenous dual chamber pacing	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	electrodes (separate procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33213	Insertion of pacemaker pulse generator only; with existing dual leads	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular	MP Criteria: Procedure/service reviewed against	4/15/2006	12/31/2999
	pacing, at time of insertion of implantable defibrillator or pacemaker pulse			
	generator (eg, for upgrade to dual chamber system) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)	İ '		
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	for long-term hemodynamic monitoring, including deployment and	Medical Policy Criteria. Submit for Recommended		
	calibration of the sensor, right heart catheterization, selective pulmonary	Clinical Review to avoid post-service review.		
	catheterization, radiological supervision and interpretation, and pulmonary	l '		
	artery angiography, when performed			
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
•	valve; percutaneous femoral artery approach	Medical Policy Criteria. Submit for Recommended		
	, ,	Clinical Review to avoid post-service review.		
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; open femoral artery approach	Medical Policy Criteria. Submit for Recommended	=	
	, Spain contains and J approach	Clinical Review to avoid post-service review.		
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; open axillary artery approach	Medical Policy Criteria. Submit for Recommended	, .,	1.2,01,2000
	vario, open axillary artery approach	Clinical Review to avoid post-service review.		
	I.	Omnoai Neview to avoid post-service review.	!	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; open iliac artery approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	11/1/2015	12/31/2999
	valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	valve; transapical exposure (eg, left thoracotomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	valve; cardiopulmonary bypass support with percutaneous peripheral	Medical Policy Criteria. Submit for Recommended	., ., =	
	arterial and venous cannulation (eg, femoral vessels) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)	Cirrical Notion to avoid poor solvies review.		
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
30000	valve; cardiopulmonary bypass support with open peripheral arterial and	Medical Policy Criteria. Submit for Recommended	17 1720 10	12/01/2000
	venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in	Clinical Review to avoid post-service review.		
	addition to code for primary procedure)	Cliffical Neview to avoid post-service review.		
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
33303	valve; cardiopulmonary bypass support with central arterial and venous	Medical Policy Criteria. Submit for Recommended	1/1/2013	12/51/2999
	cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in	Clinical Review to avoid post-service review.		
		Cliffical Review to avoid post-service review.		
33418	addition to code for primary procedure)	MD Criteria: Dragadura/agrica ravioused against	2/15/2016	12/31/2999
33418	Transcatheter mitral valve repair, percutaneous approach, including	MP Criteria: Procedure/service reviewed against	2/15/2016	12/31/2999
	transseptal puncture when performed; initial prosthesis	Medical Policy Criteria. Submit for Recommended		
00.477		Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
33477	Transcatheter pulmonary valve implantation, percutaneous approach,	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	including pre-stenting of the valve delivery site, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33927	Implantation of a total replacement heart system (artificial heart) with	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	recipient cardiectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33928	Removal and replacement of total replacement heart system (artificial	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	heart)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
33999	Unlisted procedure, cardiac surgery	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36465	Injection of non-compounded foam sclerosant with ultrasound	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	compression maneuvers to guide dispersion of the injectate, inclusive of	Medical Policy Criteria. Submit for Recommended		
	all imaging guidance and monitoring; single incompetent extremity truncal	Clinical Review to avoid post-service review.		
	vein (eg, great saphenous vein, accessory saphenous vein)	· ·		
36466	Injection of non-compounded foam sclerosant with ultrasound	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	compression maneuvers to guide dispersion of the injectate, inclusive of	Medical Policy Criteria. Submit for Recommended	1	
	all imaging guidance and monitoring; multiple incompetent truncal veins	Clinical Review to avoid post-service review.		
	(eg, great saphenous vein, accessory saphenous vein), same leg		1	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
** : * *	,(-, -: 55:5:55am (5: 5p.a5: 75:15 (15:a.).g.55:a5ia/, iiiib of dain	Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
	· ·	Chillion I to view to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36471	Injection of sclerosant; multiple incompetent veins (other than	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	telangiectasia), same leg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, radiofrequency; first	Medical Policy Criteria. Submit for Recommended		
	vein treated	Clinical Review to avoid post-service review.		
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, radiofrequency;	Medical Policy Criteria. Submit for Recommended		
	subsequent vein(s) treated in a single extremity, each through separate	Clinical Review to avoid post-service review.		
	access sites (List separately in addition to code for primary procedure)			
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
	all imaging guidance and monitoring, percutaneous, laser; first vein	Medical Policy Criteria. Submit for Recommended	J = 2 2 2	
	treated	Clinical Review to avoid post-service review.		
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of	MP Criteria: Procedure/service reviewed against	8/1/2006	12/31/2999
30 1. 0	all imaging guidance and monitoring, percutaneous, laser; subsequent	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	vein(s) treated in a single extremity, each through separate access sites	Clinical Review to avoid post-service review.		
	(List separately in addition to code for primary procedure)	Cililical Neview to avoid post-service review.		
36482	Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against	9/1/2019	12/31/2999
00402	transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote	Medical Policy Criteria. Submit for Recommended	9/1/2019	12/31/2999
	from the access site, inclusive of all imaging guidance and monitoring.	Clinical Review to avoid post-service review.		
	, , , , , , , , , , , , , , , , , , , ,	Clinical Review to avoid post-service review.		
36483	percutaneous; first vein treated Endovenous ablation therapy of incompetent vein, extremity, by	MP Criteria: Procedure/service reviewed against	9/1/2019	12/31/2999
30403	· · · · · · · · · · · · · · · · · · ·		9/1/2019	12/31/2999
	transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote	Medical Policy Criteria. Submit for Recommended		
	from the access site, inclusive of all imaging guidance and monitoring,	Clinical Review to avoid post-service review.		
	percutaneous; subsequent vein(s) treated in a single extremity, each			
	through separate access sites (List separately in addition to code for			
20500	primary procedure)	MD 0 '' : D	4/4/4050	40/04/0000
36522	Photopheresis, extracorporeal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	4.4.4.5.0000	10/04/0000
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery,	MP Criteria: Procedure/service reviewed against	11/15/2006	12/31/2999
	open or percutaneous, including angioplasty, when performed, and	Medical Policy Criteria. Submit for Recommended		
	radiological supervision and interpretation; with distal embolic protection	Clinical Review to avoid post-service review.		
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	open or percutaneous, including angioplasty, when performed, and	Medical Policy Criteria. Submit for Recommended		
	radiological supervision and interpretation; without distal embolic	Clinical Review to avoid post-service review.		
	protection			
37217	Transcatheter placement of intravascular stent(s), intrathoracic common	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
	carotid artery or innominate artery by retrograde treatment, open	Medical Policy Criteria. Submit for Recommended		
	ipsilateral cervical carotid artery exposure, including angioplasty, when	Clinical Review to avoid post-service review.		
	performed, and radiological supervision and interpretation			
37218	Transcatheter placement of intravascular stent(s), intrathoracic common	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	carotid artery or innominate artery, open or percutaneous antegrade	Medical Policy Criteria. Submit for Recommended		
	approach, including angioplasty, when performed, and radiological	Clinical Review to avoid post-service review.		1
	supervision and interpretation			1

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

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	8/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38204	Management of recipient hematopoietic progenitor cell donor search and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	cell acquisition	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	per collection; allogeneic	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and storage	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
38208	Transplant preparation of hematopoietic progenitor cells; thawing of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	previously frozen harvest, without washing, per donor	Medical Policy Criteria. Submit for Recommended		
	3,1	Clinical Review to avoid post-service review.		
38209	Transplant preparation of hematopoietic progenitor cells; thawing of	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	previously frozen harvest, with washing, per donor	Medical Policy Criteria. Submit for Recommended		
	μ· - · · · - · · · · · · · · · · · · · ·	Clinical Review to avoid post-service review.		
38210	Transplant preparation of hematopoietic progenitor cells; specific cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
332.3	depletion within harvest, T-cell depletion	Medical Policy Criteria. Submit for Recommended	., .,	.=,0.,,=000
	depletion main harveet, i con depletion	Clinical Review to avoid post-service review.		
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00211	depletion	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	doplotion	Clinical Review to avoid post-service review.		
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
002.2	removal	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	Tomovai	Clinical Review to avoid post-service review.		
38213	Transplant preparation of hematopoietic progenitor cells; platelet	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00210	depletion	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	doplotion	Clinical Review to avoid post-service review.		
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
00214	depletion	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	depietion	Clinical Review to avoid post-service review.		
38215	Transplant preparation of hematopoietic progenitor cells; cell	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
30213	concentration in plasma, mononuclear, or buffy coat layer	Medical Policy Criteria. Submit for Recommended	1/1/1930	12/31/2999
	Concentration in plasma, monoridolear, or bully coat layer	Clinical Review to avoid post-service review.		
38232	Bone marrow harvesting for transplantation; autologous	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
30232	bone manow harvesting for transplantation, autologous	Medical Policy Criteria. Submit for Recommended	1/1/2012	12/31/2999
		Clinical Review to avoid post-service review.		
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
36240	The matopoletic progenitor cell (HPC), allogenetic transplantation per donor		1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
38242	Allogeneic lymphocyte infusions	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/1950	12/21/2000
J0Z4Z	Allogeneic lymphocyte iniusions	•	1/ 1/ 1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
00010	11 (17) (17) (17) (17)	Clinical Review to avoid post-service review.	4/4/0040	10/04/0000
38243	Hematopoietic progenitor cell (HPC); HPC boost	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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	12/1/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
11120	Glossectomy; less than one-half tongue	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
41512	Tongue base suspension, permanent suture technique	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites,	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	per session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
41872	Gingivoplasty, each quadrant (specify)	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
42140	Uvulectomy, excision of uvula	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	J	Medical Policy Criteria. Submit for Recommended	1.0,=222	
		Clinical Review to avoid post-service review.		
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
12110	uvulopharyngoplasty)	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
		Clinical Review to avoid post-service review.		
12950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
1 2330	That ying opiastly (plastic of reconstructive operation on pharythy)	Medical Policy Criteria. Submit for Recommended	0/10/2024	12/01/2000
		Clinical Review to avoid post-service review.		
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
40200	submucosal injection(s), any substance	Medical Policy Criteria. Submit for Recommended	1/1/1930	12/31/2999
	Submucosal injection(s), any substance	Clinical Review to avoid post-service review.		
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal	MP Criteria: Procedure/service reviewed against	5/1/2010	12/31/2999
40201		Medical Policy Criteria. Submit for Recommended	5/1/2010	12/31/2999
	for treatment of gastroesophageal reflux disease	Clinical Review to avoid post-service review.		
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure,	MP Criteria: Procedure/service reviewed against	1/1/2017	12/31/2999
43204	placement of sphincter augmentation device (ie, magnetic band),	Medical Policy Criteria. Submit for Recommended	1/1/2017	12/31/2999
	· · · · · · · · · · · · · · · · · · ·	•		
13289	including cruroplasty when performed	Clinical Review to avoid post-service review.	6/1/2017	12/31/2999
+3209	Unlisted laparoscopy procedure, esophagus	MP Criteria: Procedure/service reviewed against	0/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
40000	Continuations and distribution of the continuation of the continua	Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
43632	Gastrectomy, partial, distal; with gastrojejunostomy	MP Criteria: Procedure/service reviewed against	6/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
40000		Clinical Review to avoid post-service review.	7/4/0007	40/04/0000
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	MP Criteria: Procedure/service reviewed against	7/1/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	4440005	10/04/0055
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
	and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	and small intestine reconstruction to limit absorption	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	adjustable gastric restrictive device (eg, gastric band and subcutaneous	Medical Policy Criteria. Submit for Recommended		
	port components)	Clinical Review to avoid post-service review.		
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	replacement of adjustable gastric restrictive device component only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	gastric restrictive device and subcutaneous port components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	gastrectomy (ie, sleeve gastrectomy)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity;	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	vertical-banded gastroplasty	Medical Policy Criteria. Submit for Recommended		
	10 to a can a car gard op acty	Clinical Review to avoid post-service review.		
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity;	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	other than vertical-banded gastroplasty	Medical Policy Criteria. Submit for Recommended	1, 1, 1000	12/01/2000
	Sanot man volusal santasa gasa spiassy	Clinical Review to avoid post-service review.		
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving	MP Criteria: Procedure/service reviewed against	9/15/2009	12/31/2999
	duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to	Medical Policy Criteria. Submit for Recommended		
	limit absorption (biliopancreatic diversion with duodenal switch)	Clinical Review to avoid post-service review.		
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	short limb (150 cm or less) Roux-en-Y gastroenterostomy	Medical Policy Criteria. Submit for Recommended	1, 1, 1000	12/01/2000
	Short limb (100 shi si 1995) Noux shi i gasa santarastaniy	Clinical Review to avoid post-service review.		
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	small intestine reconstruction to limit absorption	Medical Policy Criteria. Submit for Recommended		.=, 0 ., = 000
	Small intestine recenct dealers to limit asserption	Clinical Review to avoid post-service review.		
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
100 10	than adjustable gastric restrictive device (separate procedure)	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	than adjustable gustile restrictive device (separate procedure)	Clinical Review to avoid post-service review.		
43886	Gastric restrictive procedure, open; revision of subcutaneous port	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
10000	component only	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
	oomponent only	Clinical Review to avoid post-service review.		
43887	Gastric restrictive procedure, open; removal of subcutaneous port	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
10001	component only	Medical Policy Criteria. Submit for Recommended	1, 1,2000	1.2/01/2000
	Component only	Clinical Review to avoid post-service review.		
43888	Gastric restrictive procedure, open; removal and replacement of	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
T0000	subcutaneous port component only	Medical Policy Criteria. Submit for Recommended	1/ 1/2000	12/3/1/233
	Suboutaileous port component only	Clinical Review to avoid post-service review.		
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	· · · · · · · · · · · · · · · · · · ·	1/1/1950	12/31/2999
41310	Laparoscopy, surgical, abiation of 1 of more liver tumor(s), radiofrequency	·	1/ 1/ 1950	12/3/1/2888
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		-

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	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	, , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
0250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
	intraoperative ultrasound guidance and monitoring, if performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50360	Renal allotransplantation, implantation of graft; without recipient	MP Criteria: Procedure/service reviewed against	5/15/2016	12/31/2999
	nephrectomy	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50541	Laparoscopy, surgical; ablation of renal cysts	MP Criteria: Procedure/service reviewed against	3/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	intraoperative ultrasound guidance and monitoring, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral,	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
	radiofrequency	Medical Policy Criteria. Submit for Recommended		
	188101104801109	Clinical Review to avoid post-service review.		
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
	, with the second control of the second cont	Medical Policy Criteria. Submit for Recommended	07.172000	.=/0./=000
		Clinical Review to avoid post-service review.		
51715	Endoscopic injection of implant material into the submucosal tissues of	MP Criteria: Procedure/service reviewed against	5/1/2007	12/31/2999
017.10	the urethra and/or bladder neck	Medical Policy Criteria. Submit for Recommended	0/ 1/2001	12/01/2000
	the distilla ana/or bladder floor	Clinical Review to avoid post-service review.		
52327	Cystourethroscopy (including ureteral catheterization); with subureteric	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
02021	injection of implant material	Medical Policy Criteria. Submit for Recommended	0/1/2017	12/01/2000
	injustion of implant material	Clinical Review to avoid post-service review.		
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
02441	implant; single implant	Medical Policy Criteria. Submit for Recommended	12/1/2010	12/01/2000
	implant, single implant	Clinical Review to avoid post-service review.		
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
J2442	implant; each additional permanent adjustable transprostatic implant (List	Medical Policy Criteria. Submit for Recommended	12/1/2013	12/31/2999
	separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
54125	Amputation of penis; complete	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
34123	Amputation of penis, complete	Medical Policy Criteria. Submit for Recommended	3/1/2000	12/31/2999
		Clinical Review to avoid post-service review.		
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
J 11 00	insertion of perille prostriests, non-initiatable (settil-rigid)	Medical Policy Criteria. Submit for Recommended	1/ 1/ 1830	12/3/1/233
		1		
54401	Insertion of penile prosthesis; inflatable (self-contained)	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	insertion of pentile prostriests, initiatable (self-contained)	•	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
E 4 4 0 E	In continue of model and many to flore the second s	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
54405	Insertion of multi-component, inflatable penile prosthesis, including	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	placement of pump, cylinders, and reservoir	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54406	Removal of all components of a multi-component, inflatable penile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	prosthesis without replacement of prosthesis	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54410	Removal and replacement of all component(s) of a multi-component,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	inflatable penile prosthesis at the same operative session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54411	Removal and replacement of all components of a multi-component	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	inflatable penile prosthesis through an infected field at the same operative	Medical Policy Criteria. Submit for Recommended		
	session, including irrigation and debridement of infected tissue	Clinical Review to avoid post-service review.		
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	prosthesis, without replacement of prosthesis	Medical Policy Criteria. Submit for Recommended		
1		Clinical Review to avoid post-service review.		
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	contained) penile prosthesis at the same operative session	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-		1/1/1950	12/31/2999
	contained) penile prosthesis through an infected field at the same	Medical Policy Criteria. Submit for Recommended		
	operative session, including irrigation and debridement of infected tissue	Clinical Review to avoid post-service review.		
54660	Insertion of testicular prosthesis (separate procedure)	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided	MP Criteria: Procedure/service reviewed against	11/15/2013	12/31/2999
	saturation sampling, including imaging guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and	MP Criteria: Procedure/service reviewed against	6/15/2007	12/31/2999
	monitoring)	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
	focused ultrasound (HIFU), including ultrasound guidance	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55899	Unlisted procedure, male genital system	MP Criteria: Procedure/service reviewed against	11/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55970	Intersex surgery; male to female	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
55980	Intersex surgery; female to male	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
56805	Clitoroplasty for intersex state	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	1
		Clinical Review to avoid post-service review.		
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	MP Criteria: Procedure/service reviewed against	6/1/2008	12/31/2999
00010	- Simospiasty, repair of politicalit, nonobstatioal (separate procedure)	Medical Policy Criteria. Submit for Recommended	3/ 1/2000	1.2/01/2000
		Clinical Review to avoid post-service review.		
·		Cirriloai Neview to avoid post-service review.	_ļ	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
57291	Construction of artificial vagina; without graft	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57292	Construction of artificial vagina; with graft	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57335	Vaginoplasty for intersex state	MP Criteria: Procedure/service reviewed against	5/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic	MP Criteria: Procedure/service reviewed against	1/1/2010	12/31/2999
	approach	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
58321	Artificial insemination; intra-cervical	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	,	Plan. Not subject to pre-service review.	., .,	.=,0.,,=000
58322	Artificial insemination; intra-uterine	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, manufacture and a second	Plan. Not subject to pre-service review.	., .,	.=,0.,,=000
58323	Sperm washing for artificial insemination	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00020	openii washing for aranciai inserimation	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
58580	Transcervical ablation of uterine fibroid(s), including intraoperative	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
00000	ultrasound guidance and monitoring, radiofrequency	Medical Policy Criteria. Submit for Recommended	2/10/2024	12/01/2000
	unit asound guidance and monitoring, radionequency	Clinical Review to avoid post-service review.		
58750	Tubotubal anastomosis	Non Covered: Procedure/service not covered by the	1/15/2008	12/31/2999
30730	Tubotubai ariastoriiosis	Plan. Not subject to pre-service review.	1713/2000	12/01/2000
59072	Fetal umbilical cord occlusion, including ultrasound guidance	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
3907 Z	li etai difibilicai cord occidsiori, iricidaling ditiasodria galdance	Medical Policy Criteria. Submit for Recommended	10/1/2023	12/31/2999
		Clinical Review to avoid post-service review.		
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis),	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
39074	including ultrasound guidance	Medical Policy Criteria. Submit for Recommended	12/1/2022	12/31/2999
	including uniasound guidance	Clinical Review to avoid post-service review.		
59076	Fetal shunt placement, including ultrasound guidance	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
39070	retal shufft placement, including ultrasound guidance	Medical Policy Criteria. Submit for Recommended	10/1/2023	12/31/2999
60699	Unlisted procedure, endocrine system	Clinical Review to avoid post-service review.	10/1/2022	12/31/2999
00099	offilisted procedure, endocrine system	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	10/1/2022	12/31/2999
		,		
61635	Transcatheter placement of intravascular stent(s), intracranial (eg,	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
61635		•	11/1/2019	12/31/2999
	atherosclerotic stenosis), including balloon angioplasty, if performed	Medical Policy Criteria. Submit for Recommended		
61645	Porcutaneous arterial transluminal machanical thrambactamy and/ar	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
01040	Percutaneous arterial transluminal mechanical thrombectomy and/or	_	1/ 1/2010	12/31/2999
	infusion for thrombolysis, intracranial, any method, including diagnostic	Medical Policy Criteria. Submit for Recommended		
	angiography, fluoroscopic guidance, catheter placement, and	Clinical Review to avoid post-service review.		
64000	intraprocedural pharmacological thrombolytic injection(s)	MD Critoria: Propoduro/ogniles residented a resident	2/45/2024	10/01/0000
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	receiver, including craniectomy or craniotomy, when performed, with	Medical Policy Criteria. Submit for Recommended		
	direct or inductive coupling, with connection to depth and/or cortical strip	Clinical Review to avoid post-service review.		
	electrode array(s)			<u>J</u>

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	generator or receiver with connection to depth and/or cortical strip	Medical Policy Criteria. Submit for Recommended		
	electrode array(s)	Clinical Review to avoid post-service review.		
61892	Removal of skull-mounted cranial neurostimulator pulse generator or	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	receiver with cranioplasty, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
62268	Percutaneous aspiration, spinal cord cyst or syrinx	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
63266	Laminectomy for excision or evacuation of intraspinal lesion other than	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	neoplasm, extradural; thoracic	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
63268	Laminectomy for excision or evacuation of intraspinal lesion other than	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	neoplasm, extradural; sacral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
63271	Laminectomy for excision of intraspinal lesion other than neoplasm,	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	intradural; thoracic	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
63273	Laminectomy for excision of intraspinal lesion other than neoplasm,	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	intradural; sacral	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural,	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	thoracic	Medical Policy Criteria. Submit for Recommended	_, ,,	
		Clinical Review to avoid post-service review.		
63278	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural,	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	sacral	Medical Policy Criteria. Submit for Recommended	_, ,,	
	550.51	Clinical Review to avoid post-service review.		
63295	Osteoplastic reconstruction of dorsal spinal elements, following primary	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
00200	intraspinal procedure (List separately in addition to code for primary	Medical Policy Criteria. Submit for Recommended	2, 1, 2020	12/01/2000
	procedure)	Clinical Review to avoid post-service review.		
64555	Percutaneous implantation of neurostimulator electrode array; peripheral	MP Criteria: Procedure/service reviewed against	1/1/2022	5/14/2025
0.000	nerve (excludes sacral nerve)	Medical Policy Criteria. Submit for Recommended	., .,	07 1 172020
	Tior vo (oxolados sasial horve)	Clinical Review to avoid post-service review.		
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
0.000	treatment, includes programming	Medical Policy Criteria. Submit for Recommended	0/10/2021	12/01/2000
	a oddinoni, moradoo programming	Clinical Review to avoid post-service review.		
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
0.000	electrode array and pulse generator	Medical Policy Criteria. Submit for Recommended	17 17 2022	12/01/2000
	olootiode and paloe generator	Clinical Review to avoid post-service review.		
64575	Open implantation of neurostimulator electrode array; peripheral nerve	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
04070	(excludes sacral nerve)	Medical Policy Criteria. Submit for Recommended	17 172022	12/01/2000
	(excludes sacial fielde)	Clinical Review to avoid post-service review.		
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
UTUUU	pulse generator or receiver, requiring pocket creation and connection	Medical Policy Criteria. Submit for Recommended	1/ 1/2022	12/3/1/233
	, ° ° ' ° ' ' ° ' ' ' ' ' ' ' ' ' ' ' '	Clinical Review to avoid post-service review.	1	
64596	between electrode array and pulse generator or receiver		2/15/2024	12/31/2999
04030	Insertion or replacement of percutaneous electrode array, peripheral	MP Criteria: Procedure/service reviewed against	2/13/2024	12/31/2999
	nerve, with integrated neurostimulator, including imaging guidance, when	Medical Policy Criteria. Submit for Recommended	1	
	performed; initial electrode array	Clinical Review to avoid post-service review.		Į

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64597	Insertion or replacement of percutaneous electrode array, peripheral	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nerve, with integrated neurostimulator, including imaging guidance, when	Medical Policy Criteria. Submit for Recommended		
	performed; each additional electrode array (List separately in addition to	Clinical Review to avoid post-service review.		
	code for primary procedure)			
64620	Destruction by neurolytic agent, intercostal nerve	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64624	Destruction by neurolytic agent, genicular nerve branches including	MP Criteria: Procedure/service reviewed against	12/1/2023	12/31/2999
	imaging guidance, when performed	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
64640	Destruction by neurolytic agent; other peripheral nerve or branch	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65760	Keratomileusis	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65772	Corneal relaxing incision for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65775	Corneal wedge resection for correction of surgically induced astigmatism	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
65785	Implantation of intrastromal corneal ring segments	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66174	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without		8/15/2012	12/31/2999
	retention of device or stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66175	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with	MP Criteria: Procedure/service reviewed against	8/15/2012	12/31/2999
	retention of device or stent	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
66179	Aqueous shunt to extraocular equatorial plate reservoir, external	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
33.1.3	approach; without graft	Medical Policy Criteria. Submit for Recommended	., ., = 0 . 0	.2,0.,2000
	approach, minour grant	Clinical Review to avoid post-service review.		
66180	Aqueous shunt to extraocular equatorial plate reservoir, external	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
	approach; with graft	Medical Policy Criteria. Submit for Recommended		1.2,3 1/2000
	approach, mar grant	Clinical Review to avoid post-service review.		
66183	Insertion of anterior segment aqueous drainage device, without	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
00.100	extraocular reservoir, external approach	Medical Policy Criteria. Submit for Recommended	1, 1, 20 14	1.2/01/2000
	Total additional total total total approach	Clinical Review to avoid post-service review.		
	Į.	Cirrical Neview to avoid post-service review.	ļ	<u> </u>

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69728	Removal, entire osseointegrated implant, skull; with magnetic	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
	transcutaneous attachment to external speech processor, outside the	Medical Policy Criteria. Submit for Recommended		
	mastoid and involving a bony defect greater than or equal to 100 sq mm	Clinical Review to avoid post-service review.		
	surface area of bone deep to the outer cranial cortex	· ·		
76120	Cineradiography/videoradiography, except where specifically included	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
76125	Cineradiography/videoradiography to complement routine examination	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	(List separately in addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	MP Criteria: Procedure/service reviewed against	1/1/2005	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	blastogenesis	Medical Policy Criteria. Submit for Recommended		
	, in the second	Clinical Review to avoid post-service review.		
36910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
36911	Blood typing, for paternity testing, per individual; each additional antigen	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	system	Plan. Not subject to pre-service review.		
38000	Necropsy (autopsy), gross examination only; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
38005	Necropsy (autopsy), gross examination only; with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	7, 7, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	Plan. Not subject to pre-service review.		
38007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	7, 1, 3,7, 3	Plan. Not subject to pre-service review.		
38012	Necropsy (autopsy), gross examination only; infant with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	7,	Plan. Not subject to pre-service review.		
38014	Necropsy (autopsy), gross examination only; stillborn or newborn with	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	brain	Plan. Not subject to pre-service review.		
38016	Necropsy (autopsy), gross examination only; macerated stillborn	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	7,	Plan. Not subject to pre-service review.		
38020	Necropsy (autopsy), gross and microscopic; without CNS	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
38025	Necropsy (autopsy), gross and microscopic; with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
38027	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	1 7 1 7 7 7	Plan. Not subject to pre-service review.		
38028	Necropsy (autopsy), gross and microscopic; infant with brain	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
38029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	brain	Plan. Not subject to pre-service review.		
38036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Plan. Not subject to pre-service review.		
38037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
38040	Necropsy (autopsy); forensic examination	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	(Plan. Not subject to pre-service review.	., ., ., ., .,	1.2,0.,2000

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90885	Psychiatric evaluation of hospital records, other psychiatric reports,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	psychometric and/or projective tests, and other accumulated data for	Plan. Not subject to pre-service review.		
	medical diagnostic purposes			
90889	Preparation of report of patient's psychiatric status, history, treatment, or	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	progress (other than for legal or consultative purposes) for other	Plan. Not subject to pre-service review.		
	individuals, agencies, or insurance carriers			
92065	Orthoptic training; performed by a physician or other qualified health care	Non Covered: Procedure/service not covered by the	11/1/2013	12/31/2999
	professional	Plan. Not subject to pre-service review.		
92622	Diagnostic analysis, programming, and verification of an auditory	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	osseointegrated sound processor, any type; first 60 minutes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
92623	Diagnostic analysis, programming, and verification of an auditory	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	osseointegrated sound processor, any type; each additional 15 minutes	Medical Policy Criteria. Submit for Recommended		
	(List separately in addition to code for primary procedure)	Clinical Review to avoid post-service review.		
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
93228	External mobile cardiovascular telemetry with electrocardiographic	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
	recording, concurrent computerized real time data analysis and greater	Medical Policy Criteria. Submit for Recommended		
	than 24 hours of accessible ECG data storage (retrievable with query)	Clinical Review to avoid post-service review.		
	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			
93229	External mobile cardiovascular telemetry with electrocardiographic	MP Criteria: Procedure/service reviewed against	1/1/2020	12/31/2999
	recording, concurrent computerized real time data analysis and greater	Medical Policy Criteria. Submit for Recommended		
	than 24 hours of accessible ECG data storage (retrievable with query)	Clinical Review to avoid post-service review.		
	with ECG triggered and patient selected events transmitted to a remote	Cirrical Neview to avoid poor convice review.		
	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			
93580	Percutaneous transcatheter closure of congenital interatrial	MP Criteria: Procedure/service reviewed against	4/1/2005	12/31/2999
00000	communication (ie, Fontan fenestration, atrial septal defect) with implant	Medical Policy Criteria. Submit for Recommended	47 172000	12/01/2000
	definition out of (10, 1 of tail 10 foot attor), attail object dolost, with implant	Clinical Review to avoid post-service review.		
93660	Evaluation of cardiovascular function with tilt table evaluation, with	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	continuous ECG monitoring and intermittent blood pressure monitoring,	Medical Policy Criteria. Submit for Recommended	1, 1, 1000	12/31/2000
	with or without pharmacological intervention	Clinical Review to avoid post-service review.		
94452	High altitude simulation test (HAST), with interpretation and report by a	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
07702	physician or other qualified health care professional;	Plan. Not subject to pre-service review.	17 17 2000	12/01/2000
94453	High altitude simulation test (HAST), with interpretation and report by a	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
UTTUU	physician or other qualified health care professional; with supplemental	Plan. Not subject to pre-service review.	1/1/2003	12/3/1/2333
	oxygen titration	i iaii. Not subject to pre-service review.		
95961	Functional cortical and subcortical mapping by stimulation and/or	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
3030 I			3/1/2024	12/31/2999
	recording of electrodes on brain surface, or of depth electrodes, to	Medical Policy Criteria. Submit for Recommended		
	provoke seizures or identify vital brain structures; initial hour of	Clinical Review to avoid post-service review.		
	attendance by a physician or other qualified health care professional	J		

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96571	Photodynamic therapy by endoscopic application of light to ablate	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	abnormal tissue via activation of photosensitive drug(s); each additional	Medical Policy Criteria. Submit for Recommended		
	15 minutes (List separately in addition to code for endoscopy or	Clinical Review to avoid post-service review.		
	bronchoscopy procedures of lung and gastrointestinal tract)			
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	MP Criteria: Procedure/service reviewed against	8/15/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe	MP Criteria: Procedure/service reviewed against	7/1/2010	12/31/2999
	photoresponsive dermatoses requiring at least 4-8 hours of care under	Medical Policy Criteria. Submit for Recommended		
	direct supervision of the physician (includes application of medication and	Clinical Review to avoid post-service review.		
	dressings)	·		
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie,	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nonthermal and non-ablative) for post-operative pain reduction	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97545	Work hardening/conditioning; initial 2 hours	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97546	Work hardening/conditioning; each additional hour (List separately in	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	addition to code for primary procedure)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	minutes of personal one-on-one contact with the patient	Plan. Not subject to pre-service review.		
97811	Acupuncture, 1 or more needles; without electrical stimulation, each	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	additional 15 minutes of personal one-on-one contact with the patient,	Plan. Not subject to pre-service review.		1
	with insertion of needle(s) (List separately in addition to code for primary	I am recomposite pro connection		
	procedure)			
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	minutes of personal one-on-one contact with the patient	Plan. Not subject to pre-service review.		
97814	Acupuncture, 1 or more needles; with electrical stimulation, each	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
	additional 15 minutes of personal one-on-one contact with the patient,	Plan. Not subject to pre-service review.	., ., 2000	.=,0.,2000
	with insertion of needle(s) (List separately in addition to code for primary	Than: Not subject to pro solvice review.		
	procedure)			
99026	Hospital mandated on call service; in-hospital, each hour	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	,,	Plan. Not subject to pre-service review.		1
99027	Hospital mandated on call service; out-of-hospital, each hour	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	The second secon	Plan. Not subject to pre-service review.	., .,	.2,0.,2000
99071	Educational supplies, such as books, tapes, and pamphlets, for the	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	patient's education at cost to physician or other qualified health care	Plan. Not subject to pre-service review.	., .,	.2,0.,2000
	professional	Than: Not subject to pro solvice review.		
99075	Medical testimony	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	modelar tootimony	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
99080	Special reports such as insurance forms, more than the information	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	conveyed in the usual medical communications or standard reporting form	The state of the s	., 1, 1000	.2/01/2000
	oshroyou in the usual medical communications of standard reporting form	I lan. Not subject to pro-service review.		
99082	Unusual travel (eg, transportation and escort of patient)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	ondodal liavor (og, liansportation and escort of patient)	Plan. Not subject to pre-service review.	1, 1, 1000	12/01/2000
99175	lpecac or similar administration for individual emesis and continued	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	· · · · · · · · · · · · · · · · · · ·		1/1/1930	12/31/2999
	observation until stomach adequately emptied of poison	Plan. Not subject to pre-service review.		

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	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0200	Non-emergency transportation: ancillary: lodging escort	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0210	Non-emergency transportation: ancillary: meals-escort	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
A0426	Ambulance service, advanced life support, non-emergency transport,	MP Criteria: Procedure/service reviewed against	9/15/2014	12/31/2999
	level 1 (als 1)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0431	Ambulance service, conventional air services, transport, one way (rotary	MP Criteria: Procedure/service reviewed against	11/15/2007	12/31/2999
	wing)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A0436	Rotary wing air mileage, per statute mile	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	γ το του γ του του συνέμετα του του του του του του του του του του	Medical Policy Criteria. Submit for Recommended		1-7-11-11-11
		Clinical Review to avoid post-service review.		
A0888	Noncovered ambulance mileage, per mile (e. G., for miles traveled	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
7.0000	beyond closest appropriate facility)	Plan. Not subject to pre-service review.	17 17 202 1	12/01/2000
A2027	Matriderm, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
AZOZI	iwatilderiii, per square ceritiineter	Medical Policy Criteria. Submit for Recommended	2/10/2020	3/14/2023
		Clinical Review to avoid post-service review.		
A2028	Micromatrix flex, per mg	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
A2026	Invitorinatity flex, per frig	· ·	2/13/2023	3/14/2023
		Medical Policy Criteria. Submit for Recommended		
A2029	Minatorat was a local partity about the second partition of a	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
A2029	Mirotract wound matrix sheet, per cubic centimeter		2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
A 4400		Clinical Review to avoid post-service review.	4/4/0000	10/01/0000
A4100	Skin substitute, fda cleared as a device, not otherwise specified	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4244	Alcohol or peroxide, per pint	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4246	Betadine or phisohex solution, per pint	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4247	Betadine or iodine swabs/wipes, per box	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4335	Incontinence supply; miscellaneous	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4341	Indwelling intraurethral drainage device with valve, patient inserted,	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	replacement only, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4342	Accessories for patient inserted indwelling intraurethral drainage device	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	with valve, replacement only, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4450	Tape, non-waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4452	Tape, waterproof, per 18 square inches	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, ,, , ,	Plan. Not subject to pre-service review.		_,

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	1/1/1950	12/31/2999
11100	Troff diagno billiad for extremity	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
\4490	Surgical stockings above knee length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	g	Plan. Not subject to pre-service review.		1
N4495	Surgical stockings thigh length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
N4500	Surgical stockings below knee length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
\ 4510	Surgical stockings full length, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
\4520	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	Non Covered: Procedure/service not covered by the	1/1/2005	12/31/2999
		Plan. Not subject to pre-service review.		
44541	Monthly supplies for use of device coded at e0733	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
N4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
	auricular region, per month	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
N4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks,	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
	gel pads, electrodes, etc.), needed for one month	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
A4554	Disposable underpads, all sizes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
A4555	Electrode/transducer for use with electrical stimulation device used for	MP Criteria: Procedure/service reviewed against	6/15/2017	12/31/2999
	cancer treatment, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
N4558	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE	•	1/1/1950	12/31/2999
	(E.G., TENS, NMES), PER OZ	Plan. Not subject to pre-service review.		
N4638	Replacement battery for patient-owned ear pulse generator, each	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
\4890	Contracts, repair and maintenance, for hemodialysis equipment	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
100=		Plan. Not subject to pre-service review.	4444050	10/01/0000
\4927	Gloves, non-sterile, per 100	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
1 1001		Plan. Not subject to pre-service review.	4444050	10/01/0000
N4931	Oral thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
1 1000		Plan. Not subject to pre-service review.	4/4/4050	10/04/0000
\4932	Rectal thermometer, reusable, any type, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
10040	Course was improvemented many attacks and also 40 and to 000	Plan. Not subject to pre-service review.	4/4/4050	12/31/2999
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
A6217	adhesive border, each dressing	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
40217	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
10040	less than or equal to 48 sq. ln., without adhesive border, each dressing	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
\6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In.,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	without adhesive border, each dressing	Plan. Not subject to pre-service review.		

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		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	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	all single use system components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	single use system components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	system components (implantable)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1761	Catheter, transluminal intravascular lithotripsy, coronary	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1764	Event recorder, cardiac (implantable)	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1776	Joint device (implantable)	MP Criteria: Procedure/service reviewed against	6/1/2017	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1778	Lead, neurostimulator (implantable)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	, , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1783	Ocular implant, aqueous drainage assist device	MP Criteria: Procedure/service reviewed against	3/15/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1817	Septal defect implant system, intracardiac	MP Criteria: Procedure/service reviewed against	4/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1818	Integrated keratoprosthesis	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1820	Generator, neurostimulator (implantable), with rechargeable battery and	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	charging system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	MP Criteria: Procedure/service reviewed against	1/15/2025	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C1822	Generator, neurostimulator (implantable), high frequency, with	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	rechargeable battery and charging system	Medical Policy Criteria. Submit for Recommended	" "	
	g,gg -,	Clinical Review to avoid post-service review.		
C1824	Generator, cardiac contractility modulation (implantable)	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
= ·== ·		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
- · - - ·	sinus baroreceptor stimulation lead(s)	Medical Policy Criteria. Submit for Recommended		1
	Sinas sarorosoptor sarriaration road(o)	Clinical Review to avoid post-service review.		
C1826	Generator, neurostimulator (implantable), includes closed feedback loop	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
0.1020	leads and all implantable components, with rechargeable battery and	Medical Policy Criteria. Submit for Recommended	1,112020	12/01/2000
	charging system	Clinical Review to avoid post-service review.		1
	Managing System	Omnoai Neview to avoid post-service review.		ļ.

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1833	Monitor, cardiac, including intracardiac lead and all system components	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	(implantable)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C2624	Implantable wireless pulmonary artery pressure sensor with delivery	MP Criteria: Procedure/service reviewed against	8/16/2019	12/31/2999
	catheter, including all system components	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area up to 100 sq cm; first 25 sq cm or less wound surface	Medical Policy Criteria. Submit for Recommended		
	area	Clinical Review to avoid post-service review.		
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area up to 100 sq cm; each additional 25 sq cm wound	Medical Policy Criteria. Submit for Recommended		
	surface area, or part thereof (list separately in addition to code for primary			
	procedure)	· ·		
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area greater than or equal to 100 sq cm; first 100 sq cm	Medical Policy Criteria. Submit for Recommended		
	wound surface area, or 1% of body area of infants and children	Clinical Review to avoid post-service review.		
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
	wound surface area greater than or equal to 100 sq cm; each additional	Medical Policy Criteria. Submit for Recommended		
	100 sq cm wound surface area, or part thereof, or each additional 1% of	Clinical Review to avoid post-service review.		
	body area of infants and children, or part thereof (list separately in			
	addition to code for primary procedure)			
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
002.0	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended	., ., 2020	12/01/2000
	wound surface area up to 100 sq cm; first 25 sq cm or less wound surface			
	area	Cirrical Noview to avoid poor convice review.		
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
002.0	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended	., ., 2020	12/01/2000
	wound surface area up to 100 sq cm; each additional 25 sq cm wound	Clinical Review to avoid post-service review.		
	surface area, or part thereof (list separately in addition to code for primary	· ·		
	procedure)			
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
50211	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended	7/1/2020	12/01/2000
	wound surface area greater than or equal to 100 sq cm; first 100 sq cm	Clinical Review to avoid post-service review.		
	wound surface area, or 1% of body area of infants and children	Chillion Review to avoid post sorvice review.		
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth,	MP Criteria: Procedure/service reviewed against	4/1/2023	12/31/2999
30210	neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total	Medical Policy Criteria. Submit for Recommended	7/1/2020	12/01/2000
	wound surface area greater than or equal to 100 sq cm; each additional	Clinical Review to avoid post-service review.		
	100 sq cm wound surface area, or part thereof, or each additional 1% of	Cililical Neview to avoid post-service review.		
	body area of infants and children, or part thereof (list separately in			
C8002	addition to code for primary procedure) Preparation of skin cell suspension autograft, automated, including all	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
30002	enzymatic processing and device components (do not report with manual	Medical Policy Criteria. Submit for Recommended	3/1/2023	12/31/2999
	suspension preparation)	Clinical Review to avoid post-service review.		1
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine	MP Criteria: Procedure/service reviewed against	10/15/2014	12/31/2999
U81 U 4	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	10/13/2014	12/31/2999
	leiomyomata, with magnetic resonance (MR) guidance	Medical Policy Criteria. Submit for Recommended		1
20720	Cystowethropopy, with insertion of transpropositio implicate 4.45.2 insulants	Clinical Review to avoid post-service review.	10/1/0015	10/01/0000
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants		12/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.	1	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more	MP Criteria: Procedure/service reviewed against	12/1/2015	12/31/2999
	implants	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
C9764	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy, includes angioplasty within the same	Medical Policy Criteria. Submit for Recommended		
	vessel(s), when performed	Clinical Review to avoid post-service review.		
C9765	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy, and transluminal stent placement(s),	Medical Policy Criteria. Submit for Recommended		
	includes angioplastyš within the same vessel(s), when performed	Clinical Review to avoid post-service review.		
C9766	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy and atherectomy, includes angioplasty within	Medical Policy Criteria. Submit for Recommended		
	the same vessel(s), when performed	Clinical Review to avoid post-service review.		
C9767	Revascularization, endovascular, open or percutaneous, any vessel(s);	MP Criteria: Procedure/service reviewed against	5/15/2021	12/31/2999
	with intravascular lithotripsy and transluminal stent placement(s), and	Medical Policy Criteria. Submit for Recommended		
	atherectomy, includes angioplasty within the same vessel(s), when	Clinical Review to avoid post-service review.		
	performed			
C9782	Blinded procedure for new york heart association (nyha) class ii or iii heart	MP Criteria: Procedure/service reviewed against	2/1/2024	12/31/2999
	failure, or canadian cardiovascular society (ccs) class iii or iv chronic	Medical Policy Criteria. Submit for Recommended		
	refractory angina; transcatheter intramyocardial transplantation of	Clinical Review to avoid post-service review.		
	autologous bone marrow cells (e.g., mononuclear) or placebo control,	<u>'</u>		
	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			
C9793	3d predictive model generation for pre-planning of a cardiac procedure,	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
	using data from cardiac computed tomographic angiography and/or	Medical Policy Criteria. Submit for Recommended		
	magnetic resonance imaging with report	Clinical Review to avoid post-service review.		
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	stimulation system), including electrode and all disposable system	Medical Policy Criteria. Submit for Recommended		
	components, non-opioid medical device (must be a qualifying medicare	Clinical Review to avoid post-service review.		
	non-opioid medical device for post-surgical pain relief in accordance with			
	section 4135 of the caa, 2023)			
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max,	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	cryoice cryosphere, cryoice cryo2), including probe and all disposable	Medical Policy Criteria. Submit for Recommended		
	system components, non-opioid medical device (must be a qualifying	Clinical Review to avoid post-service review.		
	medicare non-opioid medical device for post-surgical pain relief in	Cirrical Neview to avoid poor convice fortow.		
	accordance with section 4135 of the caa, 2023)			
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
30000	disposable system components, non-opioid medical device (must be a	Medical Policy Criteria. Submit for Recommended	0/1/2020	12/01/2000
	qualifying medicare non-opioid medical device for post-surgical pain relief	1		
	in accordance with section 4135 of the caa, 2023)	Official Neview to avoid post-service review.		
D3410	apicoectomy - anterior	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
50110	apisocolomy untonor	Plan. Not subject to pre-service review.	17 17 1000	12,01,2000
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
D1210	tooth, and including elevation of mucoperiosteal flap if indicated	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
D7220	removal of impacted tooth - soft tissue	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
31220	Temoval of impacted tooth - soft tissue	•	1/1/1930	12/31/2999
		Plan. Not subject to pre-service review.		

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0274	Over-bed table	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
E0280	Bed cradle, any type	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0291	Hospital bed, fixed height, without side rails, without mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	MP Criteria: Procedure/service reviewed against	5/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0315	Bed accessory: board, table, or support device, any type	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
E0462	Rocking bed with or without side rails	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0469	Lung expansion airway clearance, continuous high frequency oscillation,	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
	and nebulization device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0492	Power source and control electronics unit for oral device/appliance for	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	neuromuscular electrical stimulation of the tongue muscle, controlled by	Medical Policy Criteria. Submit for Recommended		
	phone application	Clinical Review to avoid post-service review.		
E0493	Oral device/appliance for neuromuscular electrical stimulation of the	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	tongue muscle, used in conjunction with the power source and control	Medical Policy Criteria. Submit for Recommended		
	electronics unit, controlled by phone application, 90-day supply	Clinical Review to avoid post-service review.		
E0530	Electronic positional obstructive sleep apnea treatment, with sensor,	MP Criteria: Procedure/service reviewed against	3/1/2024	12/31/2999
	includes all components and accessories, any type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0616	Implantable cardiac event recorder with memory, activator and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	programmer	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0620	Skin piercing device for collection of capillary blood, laser, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0652	Pneumatic compressor, segmental home model with calibrated gradient	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
	pressure	Medical Policy Criteria. Submit for Recommended		
	"	Clinical Review to avoid post-service review.		
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	COMPRESSOR, TRUNK	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	leg	Medical Policy Criteria. Submit for Recommended		
	·- - 3	Clinical Review to avoid post-service review.		
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL	MP Criteria: Procedure/service reviewed against	1/1/2007	12/31/2999
	ACCESSORIES), NOT OTHERWISE SPECIFIED	Medical Policy Criteria. Submit for Recommended	., ., 2001	.2/01/2000
	1.00E000ME0), NOT OTHERWIDE OF EOH IED	Clinical Review to avoid post-service review.		
	<u> </u>	Cirrical Neview to avoid post-service review.		<u> </u>

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0677	Non-pneumatic sequential compression garment, trunk	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0678	Non-pneumatic sequential compression garment, full leg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0679	Non-pneumatic sequential compression garment, half leg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0680	Non-pneumatic compression controller with sequential calibrated gradient		2/15/2024	12/31/2999
	pressure	Medical Policy Criteria. Submit for Recommended		, .,,
	production	Clinical Review to avoid post-service review.		
E0681	Non-pneumatic compression controller without calibrated gradient	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
20001	pressure	Medical Policy Criteria. Submit for Recommended	2/10/2024	12/01/2000
	pressure	Clinical Review to avoid post-service review.		
E0682	Non-pneumatic sequential compression garment, full arm	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
L0002	Non-priedinatic sequential compression garment, full arm	Medical Policy Criteria. Submit for Recommended	2/13/2024	12/31/2999
		Clinical Review to avoid post-service review.		
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
E0003	non-prieumatic, non-sequential, peristallic wave compression pump		2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
F0000	Litter of the Book Alexander of the state of the Book Alexander of the State of the	Clinical Review to avoid post-service review.	9/1/2006	40/04/0000
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and	MP Criteria: Procedure/service reviewed against	9/1/2006	12/31/2999
	eye protection, 4 foot panel	Medical Policy Criteria. Submit for Recommended		
50500		Clinical Review to avoid post-service review.	44440=0	10/01/0000
E0700	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
	region	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the		2/15/2024	12/31/2999
	trigeminal nerve	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0735	Non-invasive vagus nerve stimulator	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0736	Transcutaneous tibial nerve stimulator	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0744	Neuromuscular stimulator for scoliosis	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0746	Electromyography (emg), biofeedback device	MP Criteria: Procedure/service reviewed against	1/1/2006	12/31/2999
_0, 10	Lissus in yography (oring), biolosabasic devise	Medical Policy Criteria. Submit for Recommended	1, 1/2000	1.2/01/2000
		Clinical Review to avoid post-service review.		
	I	Tolinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	applications	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0755	Electronic salivary reflex stimulator (intra-oral/non-invasive)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E0761	Non-thermal pulsed high frequency radiowaves, high peak power	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	electromagnetic energy treatment device	Medical Policy Criteria. Submit for Recommended		
	green and green and green and action	Clinical Review to avoid post-service review.		
E0766	Electrical stimulation device used for cancer treatment, includes all	MP Criteria: Procedure/service reviewed against	6/15/2017	12/31/2999
	accessories, any type	Medical Policy Criteria. Submit for Recommended		1, 5
	decoded in the state of the sta	Clinical Review to avoid post-service review.		
E0920	Fracture frame, attached to bed, includes weights	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
_0020	Tradition name, attached to bed, molades weights	Medical Policy Criteria. Submit for Recommended	11/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E0930	Fracture frame, free standing, includes weights	MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
L0930	rracture frame, free standing, includes weights	9	1 1/ 1/2003	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
E0946	Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	11/1/2005	12/31/2999
EU940	· ·	_	11/1/2005	12/31/2999
	poster)	Medical Policy Criteria. Submit for Recommended		
-0040		Clinical Review to avoid post-service review.	0/4/0000	40/04/0000
E0948	Fracture frame, attachments for complex cervical traction	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0984	Manual wheelchair accessory, power add-on to convert manual	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	wheelchair to motorized wheelchair, tiller control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0985	Wheelchair accessory, seat lift mechanism	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0986	Manual wheelchair accessory, push-rim activated power assist system	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	DRIVE, PAIR	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
E1005	Wheelchair accessory, power seating system, recline only, with power	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	shear reduction	Medical Policy Criteria. Submit for Recommended		1, 5
	Shoul rouddion	Clinical Review to avoid post-service review.		
E1006	Wheelchair accessory, power seating system, combination tilt and recline,		6/1/2006	12/31/2999
21000	without shear reduction	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	without shear reduction	Clinical Review to avoid post-service review.		
E1008	Wheelchair accessory, power seating system, combination tilt and recline,		6/1/2006	12/31/2999
L 1000	with power shear reduction	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	with power streat reduction			1
T1000	Who alsheir accessory addition to never continuous to the second	Clinical Review to avoid post-service review.	6/1/2006	12/31/2999
E1009	Wheelchair accessory, addition to power seating system, mechanically	MP Criteria: Procedure/service reviewed against	0/1/2000	12/31/2999
	linked leg elevation system, including pushrod and leg rest, each	Medical Policy Criteria. Submit for Recommended		1
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1010	Wheelchair accessory, addition to power seating system, power leg	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	elevation system, including leg rest, pair	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1012	Wheelchair accessory, addition to power seating system, center mount	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	power elevating leg rest/platform, complete system, any type, each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1083	Hemi-wheelchair, fixed full length arms, swing away detachable elevating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	leg rest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1085	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests		3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1087	High strength lightweight wheelchair, fixed full length arms, swing away	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	detachable elevating leg rests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1170	Amputee wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	elevating legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1171	Amputee wheelchair, fixed full length arms, without footrests or legrest	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1172	Amputee wheelchair, detachable arms (desk or full length) without	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	footrests or legrest	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1195	Heavy duty wheelchair, fixed full length arms, swing away detachable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	elevating legrests	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1227	Special height arms for wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1228	Special back height for wheelchair	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SPECIFIED	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1295	Heavy duty wheelchair, fixed full length arms, elevating legrest	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1300	Whirlpool, portable (overtub type)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, ,,	Plan. Not subject to pre-service review.		
E1301	Whirlpool tub, walk-in, portable	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
- - -	,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E1310	Whirlpool, non-portable (built-in type)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	por, non portable (bant in type)	The control of the co	., ,, ,,,,,,	.2,01,2000

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1355	Stand/rack	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1700	Jaw motion rehabilitation system	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1701	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
E1702	Replacement measuring scales for jaw motion rehabilitation system, pkg.	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	Of 200	Plan. Not subject to pre-service review.		
E2120	Pulse generator system for tympanic treatment of inner ear	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
	endolymphatic fluid	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2207	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	Non Covered: Procedure/service not covered by the	6/1/2006	12/31/2999
		Plan. Not subject to pre-service review.		
E2216	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	TIRE, ANY SIZE, EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED	Medical Policy Criteria. Submit for Recommended		
	MOVEMENT OF MULTIPLE POSITIONING FEATURES	Clinical Review to avoid post-service review.		
		· ·		
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	system, any type	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2301	Wheelchair accessory, power standing system, any type	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2310	Power wheelchair accessory, electronic connection between wheelchair	MP Criteria: Procedure/service reviewed against	9/15/2007	12/31/2999
	controller and one power seating system motor, including all related	Medical Policy Criteria. Submit for Recommended		
	electronics, indicator feature, mechanical function selection switch, and	Clinical Review to avoid post-service review.		
	fixed mounting hardware	'		
E2311	Power wheelchair accessory, electronic connection between wheelchair	MP Criteria: Procedure/service reviewed against	9/15/2007	12/31/2999
	controller and two or more power seating system motors, including all	Medical Policy Criteria. Submit for Recommended		
	related electronics, indicator feature, mechanical function selection	Clinical Review to avoid post-service review.		
	switch, and fixed mounting hardware			
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	INTERFACE, MINI-PROPORTIONAL	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	EXPANDABLE CONTROLLER,	Medical Policy Criteria. Submit for Recommended		
	,	Clinical Review to avoid post-service review.		
E2321	Power wheelchair accessory, hand control interface, remote joystick,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	nonproportional, including all related electronics, mechanical stop switch,	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1-1
	and fixed mounting hardware	Clinical Review to avoid post-service review.		
E2322	Power wheelchair accessory, hand control interface, multiple mechanical	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
- 	switches, nonproportional, including all related electronics, mechanical	Medical Policy Criteria. Submit for Recommended		
	stop switch, and fixed mounting hardware	Clinical Review to avoid post-service review.		
E2323	Power wheelchair accessory, specialty joystick handle for hand control	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	interface, prefabricated	Medical Policy Criteria. Submit for Recommended	5, 1,2000	12,01,2000
	micriaco, profabilidado			
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
= 2324	Power wheelchair accessory, chin cup for chin control interface	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2325	Power wheelchair accessory, sip and puff interface, nonproportional,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	including all related electronics, mechanical stop switch, and manual	Medical Policy Criteria. Submit for Recommended		
	swingaway mounting hardware	Clinical Review to avoid post-service review.		
2326	Power wheelchair accessory, breath tube kit for sip and puff interface	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
2327	Power wheelchair accessory, head control interface, mechanical,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	proportional, including all related electronics, mechanical direction change	Medical Policy Criteria. Submit for Recommended		
	switch, and fixed mounting hardware	Clinical Review to avoid post-service review.		
2328	Power wheelchair accessory, head control or extremity control interface,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	electronic, proportional, including all related electronics and fixed	Medical Policy Criteria. Submit for Recommended		
	mounting hardware	Clinical Review to avoid post-service review.		
2329	Power wheelchair accessory, head control interface, contact switch	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	mechanism, nonproportional, including all related electronics, mechanical	Medical Policy Criteria. Submit for Recommended	J = 2 2 2	
	stop switch, mechanical direction change switch, head array, and fixed	Clinical Review to avoid post-service review.		
	mounting hardware	Cirrical Neview to avoid post convice review.		
2330	Power wheelchair accessory, head control interface, proximity switch	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
-2000	mechanism, nonproportional, including all related electronics, mechanical	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	stop switch, mechanical direction change switch, head array, and fixed	Clinical Review to avoid post-service review.		
	mounting hardware	Official review to avoid post-service review.		
E2331	Power wheelchair accessory, attendant control, proportional, including all	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	related electronics and fixed mounting hardware	Medical Policy Criteria. Submit for Recommended	0/2 1/20 12	.=,0.,2000
	Total or of other mountaing flat aware	Clinical Review to avoid post-service review.		
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches		6/1/2006	12/31/2999
22010	1 one micronal accessery, nonetangula coat name main, 20 20 menee	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches		6/1/2006	12/31/2999
22041	1 owor whocional accessory, nonstandard sout harno watti, 24 27 mones	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
-2072	inches	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	indica	Clinical Review to avoid post-service review.		
2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
-2040	inches	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/31/2999
	liicies	Clinical Review to avoid post-service review.		
2351	Power wheelchair accessory, electronic interface to operate speech	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	generating device using power wheelchair control interface	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/31/2333
	generating device using power wheelchair control interface	,		
2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD	Clinical Review to avoid post-service review.	1/1/2012	12/31/2999
			1/ 1/2012	12/31/2999
	ACID BATTERY, EACH	Medical Policy Criteria. Submit for Recommended		
70050	DOWED WHEEL CHAID ACCESSORY ODOLID 34 SEALED LEAD ACID	Clinical Review to avoid post-service review.	4/4/0040	40/04/0000
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID		1/1/2012	12/31/2999
	BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2361	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	G. Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
	, ,	Clinical Review to avoid post-service review.		
E2364	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2365	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G.	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	Gel cell, absorbed glassmat)	Medical Policy Criteria. Submit for Recommended		
	J	Clinical Review to avoid post-service review.		
E2366	Power wheelchair accessory, battery charger, single mode, for use with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	only one battery type, sealed or non-sealed, each	Medical Policy Criteria. Submit for Recommended	J = 2 2 2	
	joing one summy type, could or non could , cuch	Clinical Review to avoid post-service review.		
E2367	Power wheelchair accessory, battery charger, dual mode, for use with	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	either battery type, sealed or non-sealed, each	Medical Policy Criteria. Submit for Recommended	0, 1,2000	12/01/2000
	John Samery type, coalies of mont coalies, cach	Clinical Review to avoid post-service review.		
E2371	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID		6/1/2006	12/31/2999
	BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	Medical Policy Criteria. Submit for Recommended	0, 1,2000	, .,,
		Clinical Review to avoid post-service review.		
E2372	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD		6/1/2006	12/31/2999
	ACID BATTERY, EACH	Medical Policy Criteria. Submit for Recommended	0, 1,2000	, .,,
	TOIS STATE ATT, ENOT	Clinical Review to avoid post-service review.		
E2373	Power wheelchair accessory, hand or chin control interface, compact	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
220.0	remote joystick, proportional, including fixed mounting hardware	Medical Policy Criteria. Submit for Recommended	0/10/2011	12/01/2000
	Torrioto Joyottok, proportional, moldanig incoa mounting hardware	Clinical Review to avoid post-service review.		
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
L2014	INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING	Medical Policy Criteria. Submit for Recommended	0/10/2014	12/01/2000
	CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED	Clinical Review to avoid post-service review.		
	ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT	Official review to avoid post service review.		
	ONLY			
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND	Medical Policy Criteria. Submit for Recommended	5, 10,2017	.2,01,2000
	MOUNTING HARDWARE, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	Medical Policy Criteria. Submit for Recommended	5, 10,2017	1.2/01/2000
	HARDWARE, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
LZJII		_	0/ 10/2014	12/3/1/233
	INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	Medical Policy Criteria. Submit for Recommended		
	HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	Clinical Review to avoid post-service review.		l

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY,	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	EACH	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2500	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, less than or equal to 8 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2502	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 8 minutes but less than or equal to 20 minutes	Medical Policy Criteria. Submit for Recommended		
	recording time	Clinical Review to avoid post-service review.		
E2504	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 20 minutes but less than or equal to 40 minutes	Medical Policy Criteria. Submit for Recommended		
	recording time	Clinical Review to avoid post-service review.		
E2506	Speech generating device, digitized speech, using pre-recorded	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	messages, greater than 40 minutes recording time	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2508	Speech generating device, synthesized speech, requiring message	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	formulation by spelling and access by physical contact with the device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2510	Speech generating device, synthesized speech, permitting multiple	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	methods of message formulation and multiple methods of device access	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2511	Speech generating software program, for personal computer or personal	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	digital assistant	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2512	Accessory for speech generating device, mounting system	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2513	Accessory for speech generating device, electromyographic sensor	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2599	Accessory for speech generating device, not otherwise classified	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
= 2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION	Medical Policy Criteria. Submit for Recommended		
	ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL	Clinical Review to avoid post-service review.		
	JOINTS)	Common to a constant of the		
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE	Medical Policy Criteria. Submit for Recommended		
	CONTROL	Clinical Review to avoid post-service review.		
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT,	MP Criteria: Procedure/service reviewed against	3/15/2014	12/31/2999
	SUPINATOR	Medical Policy Criteria. Submit for Recommended		12,5 ., 2555
	33	Clinical Review to avoid post-service review.		
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided	Non Covered: Procedure/service not covered by the	1/1/2015	12/31/2999
00210	lumbar decompression (pild) or placebo-control, performed in an	Plan. Not subject to pre-service review.	17 17 20 10	12/01/2000
	Harribar accombicación (bila) di biacció-control, benerillea ill all	I lan. 140t Subject to pre-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0293	Noncovered surgical procedure(s) using conscious sedation, regional,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	general or spinal anesthesia in a medicare qualifying clinical trial, per day	Plan. Not subject to pre-service review.		
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	only, in a medicare qualifying clinical trial, per day	Plan. Not subject to pre-service review.		
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	and infusion	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
G0552	Supply of digital mental health treatment device and initial education and	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	onboarding, per course of treatment that augments a behavioral therapy	Medical Policy Criteria. Submit for Recommended		
	plan	Clinical Review to avoid post-service review.		
90553	First 20 minutes of monthly treatment management services directly	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	related to the patient's therapeutic use of the digital mental health	Medical Policy Criteria. Submit for Recommended		
	treatment (dmht) device that augments a behavioral therapy plan,	Clinical Review to avoid post-service review.		
	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			
G0554	Each additional 20 minutes of monthly treatment management services	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
	directly related to the patient's therapeutic use of the digital mental health	Medical Policy Criteria. Submit for Recommended		
	treatment (dmht) device that augments a behavioral therapy plan,	Clinical Review to avoid post-service review.		
	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			
G2083	Office or other outpatient visit for the evaluation and management of an	MP Criteria: Procedure/service reviewed against	8/1/2021	12/31/2999
	established patient that requires the supervision of a physician or other	Medical Policy Criteria. Submit for Recommended		
	qualified health care professional and provision of greater than 56 mg	Clinical Review to avoid post-service review.		
	esketamine nasal self-administration, includes 2 hours post-			
	administration observation			
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	DOCUMENTATION AS NORMAL OR	Plan. Not subject to pre-service review.		
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	PERFORMED OR DOCUMENTED	Plan. Not subject to pre-service review.		
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	DOCUMENTATION OF THE	Plan. Not subject to pre-service review.		
G8399	Patient with documented results of a central dual-energy x-ray	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	absorptiometry (dxa) ever being performed	Plan. Not subject to pre-service review.		

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	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	Plan. Not subject to pre-service review. 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	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	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
		Plan. Not subject to pre-service review.		
	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)			
G8475	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	blocker (arb) therapy not prescribed, reason not given	Plan. Not subject to pre-service review.		
G8476	Most recent blood pressure has a systolic measurement of < 140 mmhg	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	and a diastolic measurement of < 90 mmhg	Plan. Not subject to pre-service review.		
G8477	Most recent blood pressure has a systolic measurement of >=140 mmhg	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	and/or a diastolic measurement of >=90 mmhg	Plan. Not subject to pre-service review.		
G8478	Blood pressure measurement not performed or documented, reason not	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
	given	Plan. Not subject to pre-service review.		
G8559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC	Plan. Not subject to pre-service review.		
	EVALUATION			
G8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	WITHIN THE PREVIOUS 90 DAYS	Plan. Not subject to pre-service review.		
G8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE	Plan. Not subject to pre-service review.		
	DRAINAGE MEASURE			
G8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	THE EAR WITHIN THE PREVIOUS 90 DAYS	Plan. Not subject to pre-service review.		
G8563	Patient not referred to a physician (preferably a physician with training in	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	disorders of the ear) for an otologic evaluation, reason not given	Plan. Not subject to pre-service review.		
G8564	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN	Plan. Not subject to pre-service review.		
	OTOLOGIC EVALUATION, REASON NOT SPECIFIED)	, '		
G8565	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	PROGRESSIVE HEARING LOSS	Plan. Not subject to pre-service review.		
G8566	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING	Plan. Not subject to pre-service review.		
	LOSS MEASURE	, '		
G8567	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	Plan. Not subject to pre-service review.		
G8568	Patient was not referred to a physician (preferably a physician with	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	training in disorders of the ear) for an otologic evaluation, reason not	Plan. Not subject to pre-service review.		
	given	, '		
G8569	Prolonged postoperative intubation (> 24 hrs) required	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
		Plan. Not subject to pre-service review.		
G8570	Prolonged postoperative intubation (> 24 hrs) not required	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	3 1 37 33 33 33 33 33 33 33 33 33 33 33 33	Plan. Not subject to pre-service review.	, , 24 14	, , , , , , , , , , , , , , , , , , , ,
G8575	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	DIALYSIS	Plan. Not subject to pre-service review.	, , 24 14	, , , , , , , , , , , , , , , , , , , ,
G8576	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	The state of the s	Plan. Not subject to pre-service review.		12,01,200

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8577	Re-exploration required due to mediastinal bleeding with or without	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	tamponade, unplanned coronary artery intervention (native, vessel, graft,	Plan. Not subject to pre-service review.		
	or both), valve dysfunction, aortic reintervention, or other cardiac reason			
G8578	Re-exploration not required due to mediastinal bleeding with or without	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
	tamponade, unplanned coronary artery intervention (native, vessel, graft,	Plan. Not subject to pre-service review.		
	or both), valve dysfunction, aortic reintervention, or other cardiac reason			
G8598	Aspirin or another antiplatelet therapy used	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00500	A	Plan. Not subject to pre-service review.	4/4/0040	40/04/0000
G8599	Aspirin or another antiplatelet therapy not used, reason not given	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
G8600	lv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time	Plan. Not subject to pre-service review.	1/1/2010	12/31/2999
G8000		•	1/1/2010	12/31/2999
G8601	last known well Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
G0001	time last known well for reasons documented by clinician (e.g. patient	•	1/1/2010	12/31/2999
	enrolled in clinical trial for stroke, patient admitted for elective carotid	Plan. Not subject to pre-service review.		
	intervention)			
G8602	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of	Non Covered: Procedure/service not covered by the	1/1/2010	12/31/2999
00002	time last known well, reason not given	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	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
03000	time of cancer diagnosis or recurrence (for use in a medicare-approved	Plan. Not subject to pre-service review.	1/1/2000	12/01/2000
	demonstration project)	Tian. Not subject to pre-service review.		
G9051	Oncology; primary focus of visit; treatment decision-making after disease	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	is staged or restaged, discussion of treatment options,	Plan. Not subject to pre-service review.	., .,	12/01/2000
	supervising/coordinating active cancer directed therapy or managing	,		
	consequences of cancer directed therapy (for use in a medicare-approved			
	demonstration project)			
G9052	Oncology; primary focus of visit; surveillance for disease recurrence for	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	patient who has completed definitive cancer-directed therapy and	Plan. Not subject to pre-service review.		
	currently lacks evidence of recurrent disease; cancer directed therapy			
	might be considered in the future (for use in a medicare-approved			
	demonstration project)			
G9053	Oncology; primary focus of visit; expectant management of patient with	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	evidence of cancer for whom no cancer directed therapy is being	Plan. Not subject to pre-service review.		
	administered or arranged at present; cancer directed therapy might be			
	considered in the future (for use in a medicare-approved demonstration			
	project)			
G9054	Oncology; primary focus of visit; supervising, coordinating or managing	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	care of patient with terminal cancer or for whom other medical illness	Plan. Not subject to pre-service review.		
	prevents further cancer treatment; includes symptom management, end-			
	of-life care planning, management of palliative therapies (for use in a			
COOFE	medicare-approved demonstration project)	Non Covered Procedure/semiles and severed by the	1/1/2006	10/01/0000
G9055	Oncology; primary focus of visit; other, unspecified service not otherwise	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9056	listed (for use in a medicare-approved demonstration project) Oncology; practice guidelines; management adheres to guidelines (for	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9000	use in a medicare-approved demonstration project)	· ·	1/1/2006	12/31/2999
G9057	Oncology; practice guidelines; management differs from guidelines as a	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
G9031	result of patient enrollment in an institutional review board approved	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	clinical trial (for use in a medicare-approved demonstration project)	Fian. Not subject to pre-service review.		
	Johnson that (for use in a medicare-approved demonstration project)			

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9123	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; chronic phase	Plan. Not subject to pre-service review.		
	not in hematologic, cytogenetic, or molecular remission (for use in a			
	medicare-approved demonstration project)			
G9124	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; accelerated	Plan. Not subject to pre-service review.		
	phase not in hematologic cytogenetic, or molecular remission (for use in a			
	medicare-approved demonstration project)			
G9125	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; blast phase not			
	in hematologic, cytogenetic, or molecular remission (for use in a medicare	¹		
	approved demonstration project)			
G9126	Oncology; disease status; chronic myelogenous leukemia, limited to	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	philadelphia chromosome positive and/or bcr-abl positive; in hematologic,	Plan. Not subject to pre-service review.		
	cytogenetic, or molecular remission (for use in a medicare-approved			
	demonstration project)			
G9129	Oncology; disease status; limited to multiple myeloma, systemic disease;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	stage ii or higher (for use in a medicare-approved demonstration project)	Plan. Not subject to pre-service review.		
G9130	Oncology; disease status; limited to multiple myeloma, systemic disease;	Non Covered: Procedure/service not covered by the	1/1/2006	12/31/2999
	extent of disease unknown, staging in progress, or not listed (for use in a	Plan. Not subject to pre-service review.		
	medicare-approved demonstration project)			
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU);	Plan. Not subject to pre-service review.		
	ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF			
	DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED			
	(FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)			
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
G9132	ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-	Plan. Not subject to pre-service review.	17 172007	12/31/2999
	INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY	Plant. Not subject to pre-service review.		
	OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A			
	MEDICARE-APPROVED DEMONSTRATION PROJECT)			
G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
00.00	ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL	Plan. Not subject to pre-service review.	17 17 2001	12/01/2000
	METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-	Trans. Not oubject to pro outvice feview.		
	APPROVED DEMONSTRATION PROJECT)			
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
00.07	CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT	Plan. Not subject to pre-service review.	17 17 2001	12,01,2000
	RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-	Train. Not subject to pro service review.		
	APPROVED DEMONSTRATION PROJECT)			
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT	Plan. Not subject to pre-service review.	., ., _001	.2,01,2000
	REFRACTORY (FOR USE IN A MEDICARE-APPROVED			
	DEMONSTRATION PROJECT)			
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA,	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A	Plan. Not subject to pre-service review.	., .,	.2,01,2000
	SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-	That. The subject to pro-solvinos fornow.		
	APPROVED DEMONSTRATION PROJECT)			

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE	Plan. Not subject to pre-service review.		
00400	IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)		4/4/0007	40/04/0000
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE	Plan. Not subject to pre-service review.		
	NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-			
	RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A			
G9139	MEDICARE-APPROVED DEMONSTRATION PROJECT) ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
G9139	LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE	Plan. Not subject to pre-service review.	1/1/2007	12/31/2999
	AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN,	Plan. Not subject to pre-service review.		
	STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-			
	· · · · · · · · · · · · · · · · · · ·			
G9140	APPROVED DEMONSTRATION PROJECT) FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A	Non Covered: Procedure/service not covered by the	1/1/2008	12/31/2999
03140	PATIENT STAY IN A CLINIC APPROVED FOR THE CMS	Plan. Not subject to pre-service review.	1/1/2000	12/31/2999
	DEMONSTRATION PROJECT; THE FOLLOWING MEASURES	l lan. Not subject to pre-service review.		
	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			
J0172	Injection, aducanumab-avwa, 2 mg	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0174	Injection, lecanemab-irmb, 1 mg	MP Criteria: Procedure/service reviewed against	9/15/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0218	Injection, olipudase alfa-rpcp, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0220	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE	MP Criteria: Procedure/service reviewed against	1/1/2008	12/31/2999
	SPECIFIED	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		1.212.112.2
J0222	Injection, Patisiran, 0.1 mg	MP Criteria: Procedure/service reviewed against	7/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10040		Clinical Review to avoid post-service review.		140/04/0000
J0248	Injection, remdesivir, 1mg	MP Criteria: Procedure/service reviewed against	5/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0485	Injection, belatacept, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0491	Injection, anifrolumab-fnia, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0517	Injection, benralizumab, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against	5/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0600	Injection, edetate calcium disodium, up to 1000 mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0791	Injection, crizanlizumab-tmca, 5 mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
	, ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J0888	Injectin, epoetin beta, 1 microgram, (for non esrd use)	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	[,,,	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
0.200	injourn, orpagnaceonauce and argu, o mg	Medical Policy Criteria. Submit for Recommended	.,	1.2/01/2000
		Clinical Review to avoid post-service review.		
J1301	Injection, edaravone, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	injection, established, inig	Medical Policy Criteria. Submit for Recommended	., .,	12/01/2000
		Clinical Review to avoid post-service review.		
J1302	Injection, sutimlimab-jome, 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
71002	injection, estiminas jeme, re mg	Medical Policy Criteria. Submit for Recommended	10/1/2022	12/01/2000
		Clinical Review to avoid post-service review.		
J1303	Injection, ravulizumab-cwvz, 10 mg	MP Criteria: Procedure/service reviewed against	7/15/2020	12/31/2999
71000	injodion, ravalizamas owvz, ro mg	Medical Policy Criteria. Submit for Recommended	1710/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J1304	Injection, tofersen, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
71004	injection, tolerach, 1 mg	Medical Policy Criteria. Submit for Recommended	2/10/2024	12/01/2000
		Clinical Review to avoid post-service review.		
J1305	Injection, evinacumab-dgnb, 5mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
1000	Injection, evinacumab-ugnb, Jing	Medical Policy Criteria. Submit for Recommended	10/1/2021	12/01/2000
		•		
J1306	Injection, inclisiran, 1 mg	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
1000	Injection, inclisitan, i mg	•	1/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
14007	Inication analysis ab object 40 man	Clinical Review to avoid post-service review.	2/45/2025	40/04/0000
J1307	Injection, crovalimab-akkz, 10 mg	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

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	5/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	x 10^13 vector genomes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1426	Injection, casimersen, 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1427	Injection, viltolarsen, 10 mg	MP Criteria: Procedure/service reviewed against	5/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1428	Injection, eteplirsen, 10 mg	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1429	Injection, golodirsen, 10 mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
	3 7 3	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1440	Fecal microbiota, live - jslm, 1 ml	MP Criteria: Procedure/service reviewed against	6/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1551	Injection, immune globulin (cutaquig), 100 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1554	Injection, immune globulin (asceniv), 500 mg	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g.,	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
	liquid), 500 mg	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1628	Injection, guselkumab, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	,, g,g	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1632	Injection, brexanolone, 1 mg	MP Criteria: Procedure/service reviewed against	10/1/2020	2/14/2025
	,,,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Non Covered: Procedure/service not covered by the	7/15/2023	12/31/2999
	, ., ., .,, ,	Plan. Not subject to pre-service review.		
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Non Covered: Procedure/service not covered by the	7/15/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Plan. Not subject to pre-service review.		
J1747	Injection, spesolimab-sbzo, 1 mg	MP Criteria: Procedure/service reviewed against	5/1/2023	12/31/2999
-····	,, -p	Medical Policy Criteria. Submit for Recommended	1	12/3 // 2000
		Clinical Review to avoid post-service review.	1	
J1823	Injection, inebilizumab-cdon, 1 mg	MP Criteria: Procedure/service reviewed against	3/1/2021	12/31/2999
0.1020	injourn, mosnizumus odon, i mg	Medical Policy Criteria. Submit for Recommended	0, 1, 2021	12,01/2000
		Inicalcal Folloy Official Cabillition (Coolinitellucu	1	1

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1930	INJECTION, LANREOTIDE, 1 MG	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2267	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	1/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	injection, 25 mcg	Medical Policy Criteria. Submit for Recommended		
	, , , ,	Clinical Review to avoid post-service review.		
J2356	Injection, tezepelumab-ekko, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	μη, μ-gg	Medical Policy Criteria. Submit for Recommended	_,	
		Clinical Review to avoid post-service review.		
J2782	Injection, avacincaptad pegol, 0.1 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
	Injourn, arabinsapida pogot, orr ing	Medical Policy Criteria. Submit for Recommended	.,,	.2,0.,,2000
		Clinical Review to avoid post-service review.		
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL	MP Criteria: Procedure/service reviewed against	9/1/2020	12/31/2999
52. 3.	Trabolitating of phoophiato, opinitialinito oblation, up to o me	Medical Policy Criteria. Submit for Recommended	0/ 1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J3032	Injection, eptinezumab-jjmr, 1 mg	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
30002	Injustion, optinozamab jim, i mg	Medical Policy Criteria. Submit for Recommended	11/10/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J3111	Injection, romosozumab-aqqg, 1 mg	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
50111	Injourn, fornosozumus uqqg, fing	Medical Policy Criteria. Submit for Recommended	7/1/2024	12/01/2000
		Clinical Review to avoid post-service review.		
J3241	Injection, teprotumumab-trbw, 10 mg	MP Criteria: Procedure/service reviewed against	11/1/2020	12/31/2999
JJ24 I	Injection, teprotumumas-tibw, 10 mg	Medical Policy Criteria. Submit for Recommended	11/1/2020	12/31/2999
		Clinical Review to avoid post-service review.		
J3247	Injection, secukinumab, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2024	12/31/2999
00247	Injection, secukinamab, intravenous, 1 mg	Medical Policy Criteria. Submit for Recommended	0/13/2024	12/31/2999
		Clinical Review to avoid post-service review.		
J3299	Injection, triamcinolone acetonide (xipere), 1 mg	MP Criteria: Procedure/service reviewed against	9/15/2022	12/31/2999
JJZJJ	injection, manicinolone acetonide (xipere), i mg	Medical Policy Criteria. Submit for Recommended	3/13/2022	12/3/1/2999
		1		
J3393	Unication, hatihaglagana autotomost, nor tractment	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	7/1/2024	12/21/2000
J3333	Injection, betibeglogene autotemcel, per treatment	•	1/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
10004		Clinical Review to avoid post-service review.	7/4/0004	10/04/0000
J3394	Injection, lovotibeglogene autotemcel, per treatment	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3396	INJECTION, VERTEPORFIN, 0.1 MG	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15	MP Criteria: Procedure/service reviewed against	7/1/2020	12/31/2999
	vector genomes	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3401	Beremagene geperpavec-svdt for topical administration, containing	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
	nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3520	Edetate disodium, per 150 mg	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J3570	Laetrile, amygdalin, vitamin b17	Non Covered: Procedure/service not covered by the	6/1/2015	12/31/2999
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Plan. Not subject to pre-service review.		
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN),	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	WILATE, 1 I.U. VWF:RCO	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J7311	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	MP Criteria: Procedure/service reviewed against	6/15/2011	12/31/2999
	injusticity, naconicione accionists, initiativical implant (concerty, coor inig	Medical Policy Criteria. Submit for Recommended	0, 10,2011	12/01/2000
		Clinical Review to avoid post-service review.		
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
01010	injustion, national assistance, intravition implant (nation), 6.61 mg	Medical Policy Criteria. Submit for Recommended	17 1720 10	12/01/2000
		Clinical Review to avoid post-service review.		
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
0.00.	Injustion, simuloproot, maddamoral implant, 1 moregram	Medical Policy Criteria. Submit for Recommended	10/1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
J7355	Injection, travoprost, intracameral implant, 1 microgram	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
01000	Injection, travoprost, intracameral implant, 1 microgram	Medical Policy Criteria. Submit for Recommended	17172024	12/01/2000
		Clinical Review to avoid post-service review.		
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic	MP Criteria: Procedure/service reviewed against	8/1/2023	12/31/2999
39029	dose	Medical Policy Criteria. Submit for Recommended	0/1/2023	12/31/2999
	uose	Clinical Review to avoid post-service review.		
J9037	Injection, belantamab mafodontin-blmf, 0.5 mg	Non Covered: Procedure/service not covered by the	4/1/2024	3/31/2025
39037	Injection, belantamas maiodonum-simi, 0.5 mg	Plan. Not subject to pre-service review.	4/1/2024	3/3 1/2023
J9057	Injection, copanlisib, 1 mg	Non Covered: Procedure/service not covered by the	4/1/2024	12/31/2999
39031	injection, copaniisib, i mg	· ·	4/1/2024	12/31/2999
J9285	Injection, olaratumab, 10 mg	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	9/1/2019	12/31/2999
J9200	injection, diaratumab, 10 mg		9/1/2019	12/31/2999
10242	Injection movetumemen neguratory talks 0.04 mm	Plan. Not subject to pre-service review.	4/4/2024	10/21/2000
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Non Covered: Procedure/service not covered by the	4/1/2024	12/31/2999
10000	hitestian afairtina delfa fact. On a	Plan. Not subject to pre-service review.	7/4/0000	40/04/0000
J9332	Injection, efgartigimod alfa-fcab, 2mg	MP Criteria: Procedure/service reviewed against	7/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9333	Injection, rozanolixizumab-noli, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MP Criteria: Procedure/service reviewed against	2/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9376	Injection, pozelimab-bbfg, 1 mg	MP Criteria: Procedure/service reviewed against	4/15/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
J9600	INJECTION, PORFIMER SODIUM, 75 MG	MP Criteria: Procedure/service reviewed against	2/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0010	Standard - weight frame motorized/power wheelchair	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0011	Standard - weight frame motorized/power wheelchair with programmable	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	control parameters for speed adjustment, tremor dampening, acceleration			
	control and braking	Clinical Review to avoid post-service review.		
K0014	Other motorized/power wheelchair base	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	
		Clinical Review to avoid post-service review.		
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP.	MP Criteria: Procedure/service reviewed against	8/1/2011	12/31/2999
	HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE	Medical Policy Criteria. Submit for Recommended	0, 1, 20 1 1	.=,0.,,=000
	INCHES	Clinical Review to avoid post-service review.		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
. 1.0000	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	WEIGHT ON NOTH OF TO THE INGLODING GOOT COMES	Clinical Review to avoid post-service review.		
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10001	WEIGHT CAPACITY, 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	WEIGHT GALACITT, OUT TO 4001 OUNDO	Clinical Review to avoid post-service review.		
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110002	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	ATIENT WEIGHT CALACITY 431 TO 0001 OUNDO	Clinical Review to avoid post-service review.		
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	WEIGHT CALACITY OF TO AND INCLUDING 300 FOUNDS	Clinical Review to avoid post-service review.		
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10007	WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	WEIGHT CALACITY 301 TO 4301 OUNDS	Clinical Review to avoid post-service review.		
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
K0000	PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	PATIENT WEIGHT CAPACITY 451 TO 000 POUNDS	1		
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
NU0 12	POWER OFERATED VEHICLE, NOT OTHERWISE CLASSIFIED		10/1/2000	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
1/0040	DOWER WHEEL OHAIR OROUR 4 OTANIDARD PORTARI F	Clinical Review to avoid post-service review.	40/4/0000	40/04/0000
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended		
	300 POUNDS	Clinical Review to avoid post-service review.		
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601	Medical Policy Criteria. Submit for Recommended		
	POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP			1 2 2000
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
	1107/110 INCLODING 300 F COMPC	Omnodi Roview to avoid post-solvide review.	-!	-!

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450	Medical Policy Criteria. Submit for Recommended		
	POUNDS	Clinical Review to avoid post-service review.		
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended		
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended		
	CAPACITY 601 POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Medical Policy Criteria. Submit for Recommended		
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended	1.0, 1.200	
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
. 100 10	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended	, .,	.2,0.,2000
	300 POUNDS	Clinical Review to avoid post-service review.		
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	, .,	.2,0.,2000
	TATIENT WEIGHT GALAGINE OF TO AND INCEODING GOOT GOING	Clinical Review to avoid post-service review.		
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10000	SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	SEATIBROIN, FATIENT WEIGHT GAT AGIT TO 4001 GONDO	Clinical Review to avoid post-service review.		
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110001	PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	ATIENT WEIGHT GALAGITT 301 TO 4301 GONDO	Clinical Review to avoid post-service review.		
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110002	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	OLATIDACK, FATIENT WEIGHT CAFACITE 431 TO 000 TOOMDS	Clinical Review to avoid post-service review.		
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
N0033	CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 000 POUNDS	•		
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY,	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110004	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/3//2399
	POUNDS OR MORE			
VOOEE	POUNDS OR MORE POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS	Clinical Review to avoid post-service review.	10/1/2006	10/04/0000
K0855		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Medical Policy Criteria. Submit for Recommended		
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO	Medical Policy Criteria. Submit for Recommended		
	AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450	Medical Policy Criteria. Submit for Recommended		
	POUNDS	Clinical Review to avoid post-service review.		
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended		
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP			
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110000	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	CAPACITY 451 TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	CAPACITY 601 POUNDS OR MORE	Clinical Review to avoid post-service review.		
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110000	SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	300 POUNDS	Clinical Review to avoid post-service review.		
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR,	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
110000	PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/01/2000
	I ATIENT WEIGHT CALACITY OF TO AND INCEODING 3001 COINDS	Clinical Review to avoid post-service review.		
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10070	SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	OLAT/BACK, FATILINE WEIGHT GAFAGITE 301 TO 430 FOUNDS	Clinical Review to avoid post-service review.		
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
10071	SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	OLAT/BACK, FATILINE WEIGHT GAFAGITT 431 TO 000 TOOMBO	Clinical Review to avoid post-service review.		
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
NOO! !	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	•	10/1/2000	12/31/2333
		1		
K0878	TO AND INCLUDING 300 POUNDS POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
1,0070		Medical Policy Criteria. Submit for Recommended	10/1/2000	12/31/2999
	OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO			
V0070	AND INCLUDING 300 POUNDS POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER	Clinical Review to avoid post-service review.	10/1/2006	10/21/2000
K0879		MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451	Medical Policy Criteria. Submit for Recommended		
	TO 600 POUNDS	Clinical Review to avoid post-service review.		
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Medical Policy Criteria. Submit for Recommended		
	TO AND INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND	Medical Policy Criteria. Submit for Recommended		
	INCLUDING 300 POUNDS	Clinical Review to avoid post-service review.		
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY	Medical Policy Criteria. Submit for Recommended		
	301 TO 450 POUNDS	Clinical Review to avoid post-service review.		
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	Medical Policy Criteria. Submit for Recommended		
	TO AND INCLUDING 125 POUNDS	Clinical Review to avoid post-service review.		
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
	OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP	_		
	TO AND INCLUDING 125 POUNDS	Clinical Review to avoid post-service review.		
K0899	Power mobile device; no dme pdac	MP Criteria: Procedure/service reviewed against	10/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
K1030	External recharging system for battery (internal) for use with implanted	MP Criteria: Procedure/service reviewed against	4/1/2022	12/31/2999
	cardiac contractility modulation generator, replacement only	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	circumferential frame with anterior and posterior rigid pads, custom	Medical Policy Criteria. Submit for Recommended		
	fabricated	Clinical Review to avoid post-service review.		
L1834	Knee orthosis, without knee joint, rigid, custom-fabricated	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., .,	
		Clinical Review to avoid post-service review.		
L1840	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament,	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	custom fabricated	Medical Policy Criteria. Submit for Recommended	., .,	1.2,01,2000
		Clinical Review to avoid post-service review.		
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR	Medical Policy Criteria. Submit for Recommended	., .,	1.2,01,2000
	POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH			
	OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM	Similar Neview to avoid poor convice fortion.		
	FABRICATED			
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
	ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR	Medical Policy Criteria. Submit for Recommended	., ., 1000	12,01,2000
	POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH			
	OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM	Official Noview to avoid post-service review.		
	FABRICATED			
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
LUU-TU	Toot, aron support, removable, premolecu, longitudinal, each	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
L3030	Toot, alon support, removable, premoteu, metataisai, each	Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
		Fian. Not subject to pre-service review.		

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	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
L5610	Addition to lower extremity, endoskeletal system, above knee,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	hydracadence system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5611	Addition to lower extremity, endoskeletal system, above knee - knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with friction swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5613	Addition to lower extremity, endoskeletal system, above knee-knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with hydraulic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5614	Addition to lower extremity, exoskeletal system, above knee-knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation, 4 bar linkage, with pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	swing and stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5616	Addition to lower extremity, endoskeletal system, above knee, universal	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	multiplex system, friction swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5620	Addition to lower extremity, test socket, below knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	,,, ,,, ,	Medical Policy Criteria. Submit for Recommended		1.2.0
		Clinical Review to avoid post-service review.		
L5624	Addition to lower extremity, test socket, above knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	, talinon to forto state state, alone talino	Medical Policy Criteria. Submit for Recommended	0, 1,2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5629	Addition to lower extremity, below knee, acrylic socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	, talino, to tono, other miles, as you could	Medical Policy Criteria. Submit for Recommended	0, 1,2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	socket	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	.2,0.,2000
	SOUNCE	Clinical Review to avoid post-service review.		
_5638	Addition to lower extremity, below knee, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	, radius. To rond. Samoning, 201011 tares, realis. Societ	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	.2,0.,2000
		Clinical Review to avoid post-service review.		
L5639	Addition to lower extremity, below knee, wood socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20000	radition to lower statement, bolow talloo, wood cooker	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5640	Addition to lower extremity, knee disarticulation, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20040	Addition to lower extremity, those distribution, realiter society	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
_5642	Addition to lower extremity, above knee, leather socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
LUU 12	, ladition to lower extremity, above know, leating sound	Medical Policy Criteria. Submit for Recommended	3, 1/2000	1.2/01/2000
		Clinical Review to avoid post-service review.		
_5644	Addition to lower extremity, above knee, wood socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
LJUTT	Addition to lower extremity, above kneet, wood socket	_	0/1/2000	12/3/1/233
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		ı

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5645	Addition to lower extremity, below knee, flexible inner socket, external	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	frame	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5646	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	socket	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5647	Addition to lower extremity, below knee suction socket	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5648	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	socket	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5651	Addition to lower extremity, above knee, flexible inner socket, external	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	frame	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5652	Addition to lower extremity, suction suspension, above knee or knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	disarticulation socket	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5670	Addition to lower extremity, below knee, molded supracondylar	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	suspension ('pts' or similar)	Medical Policy Criteria. Submit for Recommended	· · · = · · · ·	
	(F	Clinical Review to avoid post-service review.		
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	,,, γ, γ, γ, γ, γ, γ	Medical Policy Criteria. Submit for Recommended	· · · = · · · ·	
		Clinical Review to avoid post-service review.		
L5704	Custom shaped protective cover, below knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended	· · · = · · · ·	
		Clinical Review to avoid post-service review.		
L5705	Custom shaped protective cover, above knee	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	oustern entaped protective cover, also to tallo	Medical Policy Criteria. Submit for Recommended	07.172000	1.270 172000
		Clinical Review to avoid post-service review.		
L5706	Custom shaped protective cover, knee disarticulation	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	oustern or tapes processing correct, range alout accumulation.	Medical Policy Criteria. Submit for Recommended	07.172000	1.270 172000
		Clinical Review to avoid post-service review.		
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20.10	radiati, executerariate etim eyetetti, ettigle axie, manaarieek	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20711	light material	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	ingrit material	Clinical Review to avoid post-service review.		
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
LOT 12	stance phase control (safety knee)	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/01/2000
	Starice priase control (salety knee)	Clinical Review to avoid post-service review.		
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
LUIT	· · · · · · · · · · · · · · · · · · ·	_	0/ 1/2000	12/3/1/233
	swing phase control	Medical Policy Criteria. Submit for Recommended		
L E 7 1 C	Addition every closed known chip queters are becauties asset as its lateral a	Clinical Review to avoid post-service review.	6/4/2006	10/01/0000
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase lock	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.	<u> </u>	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	friction stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
	ľ	Clinical Review to avoid post-service review.		
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	(titanium, carbon fiber or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	light material	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control (safety knee)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control, mechanical stance phase lock	Medical Policy Criteria. Submit for Recommended	· · · = · · · ·	
	F	Clinical Review to avoid post-service review.		
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase lock	Medical Policy Criteria. Submit for Recommended		1 2 2
	phase took	Clinical Review to avoid post-service review.		
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended	1	1.2,0.,.2000
	Statistics prides sortion	Clinical Review to avoid post-service review.	1	
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
L0022	friction stance phase control	Medical Policy Criteria. Submit for Recommended	0, 1/2000	12/01/2000
	motion statice phase control	Clinical Review to avoid post-service review.	1	
	<u>_</u>	Cililical Ineview to avoid post-service review.		_

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control, with miniature high activity frame	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	stance phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	pneumatic swing phase control	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing,	MP Criteria: Procedure/service reviewed against	4/1/2024	12/31/2999
	and stance phase control	Medical Policy Criteria. Submit for Recommended		
	· '	Clinical Review to avoid post-service review.		
L5848	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE		6/1/2006	12/31/2999
	EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT	Medical Policy Criteria. Submit for Recommended		
	ADJUSTABILITY	Clinical Review to avoid post-service review.		
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE,	Medical Policy Criteria. Submit for Recommended		
	SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S),			
	ANY TYPE			
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL	MP Criteria: Procedure/service reviewed against	5/15/2007	12/31/2999
	KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE,	Medical Policy Criteria. Submit for Recommended	0, 10, 200	
	STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY	Clinical Review to avoid post-service review.		
	TYPE	Chillied Neview to avoid poor solvies review.		
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system,	MP Criteria: Procedure/service reviewed against	1/1/2013	12/31/2999
	powered and programmable flexion/extension assist control, includes any			
	type motor(s)	Clinical Review to avoid post-service review.		
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation,	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
	above knee, hip disarticulation, positional rotation unit, any type	Medical Policy Criteria. Submit for Recommended	0, 10, 202	
	azoro inioo, inp alosi aosianon, poolaona rotanon ann, any type	Clinical Review to avoid post-service review.		
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT,	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
	PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL,	Medical Policy Criteria. Submit for Recommended		12,01,2000
	WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	Clinical Review to avoid post-service review.		
L5962	Addition, endoskeletal system, below knee, flexible protective outer	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	surface covering system	Medical Policy Criteria. Submit for Recommended	5, ., 2000	.2,31,2000
	Sando overing system	Clinical Review to avoid post-service review.		
L5964	Addition, endoskeletal system, above knee, flexible protective outer	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20007	surface covering system	Medical Policy Criteria. Submit for Recommended	5, 1/2000	.2/01/2000
	January Covering System	Clinical Review to avoid post-service review.		
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer		6/1/2006	12/31/2999
L0300	surface covering system	Medical Policy Criteria. Submit for Recommended	0/1/2000	12/31/2333
	Surface covering system	•		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active	MP Criteria: Procedure/service reviewed against	4/15/2015	12/31/2999
	dorsiflexion feature	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes	MP Criteria: Procedure/service reviewed against	1/1/2014	12/31/2999
	any type motor(s)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5970	All lower extremity prostheses, foot, external keel, sach foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5972	All lower extremity prostheses, foot, flexible keel	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR	Medical Policy Criteria. Submit for Recommended		
	FLEXION CONTROL, INCLUDES POWER SOURCE	Clinical Review to avoid post-service review.		
L5974	All lower extremity prostheses, foot, single axis ankle/foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5976	All lower extremity prostheses, energy storing foot (seattle carbon copy ii	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	or equal)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5979	All lower extremity prosthesis, multi-axial ankle, dynamic response foot,	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	one piece system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5980	All lower extremity prostheses, flex foot system	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5981	All lower extremity prostheses, flex-walk system or equal	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L5982	All exoskeletal lower extremity prostheses, axial rotation unit	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	,, , , ,, , , ,, , ,	Medical Policy Criteria. Submit for Recommended	· · · = · · · ·	
		Clinical Review to avoid post-service review.		
L5984	All endoskeletal lower extremity prosthesis, axial rotation unit, with or	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	without adjustability	Medical Policy Criteria. Submit for Recommended	07.172000	.=/0./=000
	This is a square and the square and	Clinical Review to avoid post-service review.		
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
20000	The original letter extremity produced, dynamic products pylon	Medical Policy Criteria. Submit for Recommended	0/ 1/2000	12/01/2000
		Clinical Review to avoid post-service review.		
L5986	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
	The second of the probabood, main-axial rotation unit (mop of equal)	Medical Policy Criteria. Submit for Recommended	3, 1/2000	1.2/01/2000
		Clinical Review to avoid post-service review.	1	
L5987	All lower extremity prosthesis, shank foot system with vertical loading	MP Criteria: Procedure/service reviewed against	6/1/2006	12/31/2999
LJaui		Medical Policy Criteria. Submit for Recommended	0/1/2000	12/3/1/2888
	pylon		1	
		Clinical Review to avoid post-service review.	<u> </u>	

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6026		MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
	power, self-suspended, inner socket with removable forearm section,	Medical Policy Criteria. Submit for Recommended		
	electrodes and cables, two batteries, charger, myoelectric control of	Clinical Review to avoid post-service review.		
	terminal device, excludes terminal device(s)			
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	POWERED, ADDITIONAL SWITCH, ANY TYPE	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L6621		MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL	Medical Policy Criteria. Submit for Recommended		
	POWERED TERMINAL DEVICE	Clinical Review to avoid post-service review.		
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED,	MP Criteria: Procedure/service reviewed against	1/1/2012	12/31/2999
	INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR	Medical Policy Criteria. Submit for Recommended		
	COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	Clinical Review to avoid post-service review.		
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L6920	Wrist disarticulation, external power, self-suspended inner socket,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
	and one charger, switch control of terminal device	Clinical Review to avoid post-service review.		
L6925	Wrist disarticulation, external power, self-suspended inner socket,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	removable forearm shell, otto bock or equal electrodes, cables, two	Medical Policy Criteria. Submit for Recommended	., ., 2000	.2,0.,2000
	batteries and one charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6930	Below elbow, external power, self-suspended inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
20000	forearm shell, otto bock or equal switch, cables, two batteries and one	Medical Policy Criteria. Submit for Recommended	4/ 1/2000	12/01/2000
	charger, switch control of terminal device	Clinical Review to avoid post-service review.		
L6935	Below elbow, external power, self-suspended inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0933	forearm shell, otto bock or equal electrodes, cables, two batteries and one		4/1/2009	12/31/2999
	charger, myoelectronic control of terminal device	Clinical Review to avoid post-service review.		
L6940	Elbow disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L0940		Medical Policy Criteria. Submit for Recommended	4/1/2009	12/31/2999
		1		
1.0045	cables, two batteries and one charger, switch control of terminal device	Clinical Review to avoid post-service review.	4/1/2009	40/04/0000
L6945	Elbow disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	humeral shell, outside locking hinges, forearm, otto bock or equal	Medical Policy Criteria. Submit for Recommended		
	electrodes, cables, two batteries and one charger, myoelectronic control	Clinical Review to avoid post-service review.		
1.0050	of terminal device	MD Oritorio December / comito consistent	4/4/0000	40/04/0000
L6950	Above elbow, external power, molded inner socket, removable humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shell, internal locking elbow, forearm, otto bock or equal switch, cables,	Medical Policy Criteria. Submit for Recommended		
	two batteries and one charger, switch control of terminal device	Clinical Review to avoid post-service review.	4440000	10/01/0000
L6955	Above elbow, external power, molded inner socket, removable humeral	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shell, internal locking elbow, forearm, otto bock or equal electrodes,	Medical Policy Criteria. Submit for Recommended		
	cables, two batteries and one charger, myoelectronic control of terminal	Clinical Review to avoid post-service review.		
	device			
L6960	Shoulder disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal switch, cables, two batteries and one charger,	Clinical Review to avoid post-service review.		
	switch control of terminal device			<u> </u>

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6965	Shoulder disarticulation, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal electrodes, cables, two batteries and one	Clinical Review to avoid post-service review.		
	charger, myoelectronic control of terminal device			
L6970	Interscapular-thoracic, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal switch, cables, two batteries and one charger,	Clinical Review to avoid post-service review.		
	switch control of terminal device	·		
L6975	Interscapular-thoracic, external power, molded inner socket, removable	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	shoulder shell, shoulder bulkhead, humeral section, mechanical elbow,	Medical Policy Criteria. Submit for Recommended		
	forearm, otto bock or equal electrodes, cables, two batteries and one	Clinical Review to avoid post-service review.		
	charger, myoelectronic control of terminal device			
_7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	PEDIATRIC	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED,	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	ADULT	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	· ·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED.	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	PEDIATRIC	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7170	Electronic elbow, hosmer or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7180	Electronic elbow, microprocessor sequential control of elbow and terminal	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	device	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
	CONTROL OF ELBOW AND TERMINAL DEVICE	Medical Policy Criteria. Submit for Recommended		
	00111102 01 22301171113 12111111111111111111111111111111	Clinical Review to avoid post-service review.		
_7185	Electronic elbow, adolescent, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., ., 2000	.2,0.,2000
		Clinical Review to avoid post-service review.		
_7186	Electronic elbow, child, variety village or equal, switch controlled	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
27 100	Libertonia dibert, orina, variety vinage of equal, evitor controlled	Medical Policy Criteria. Submit for Recommended	17 17 2000	12/01/2000
		Clinical Review to avoid post-service review.		
_7190	Electronic elbow, adolescent, variety village or equal, myoelectronically	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
L1 100	controlled	Medical Policy Criteria. Submit for Recommended	7, 1/2003	12/01/2000
	CONTROLLEG	Clinical Review to avoid post-service review.	1	
L7191	Electronic elbow, child, variety village or equal, myoelectronically	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
_1 131	controlled	•	4/1/2009	12/31/2999
	Controlled	Medical Policy Criteria. Submit for Recommended	1	
		Clinical Review to avoid post-service review.		ı

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7259	Electronic wrist rotator, any type	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7360	Six volt battery, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_7362	Battery charger, six volt, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7364	Twelve volt battery, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7366	Battery charger, twelve volt, each	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7367	Lithium ion battery, rechargeable, replacement	MP Criteria: Procedure/service reviewed against	4/1/2009	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	MP Criteria: Procedure/service reviewed against	7/15/2007	12/31/2999
		Medical Policy Criteria. Submit for Recommended		1,
		Clinical Review to avoid post-service review.		
L8604	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID	MP Criteria: Procedure/service reviewed against	1/1/2009	12/31/2999
	COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES	Medical Policy Criteria. Submit for Recommended		1,
	SHIPPING AND NECESSARY SUPPLIES	Clinical Review to avoid post-service review.		
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe,	MP Criteria: Procedure/service reviewed against	5/1/2007	12/31/2999
	includes shipping and necessary supplies	Medical Policy Criteria. Submit for Recommended	0, 1, = 1 1	1,
	mistages simpping and necessary supplies	Clinical Review to avoid post-service review.		
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes	MP Criteria: Procedure/service reviewed against	1/1/2016	12/31/2999
	shipping and necessary supplies	Medical Policy Criteria. Submit for Recommended		1,
	Supplied and reseason y supplies	Clinical Review to avoid post-service review.		
L8609	ARTIFICIAL CORNEA	MP Criteria: Procedure/service reviewed against	1/1/2015	12/31/2999
		Medical Policy Criteria. Submit for Recommended	., ., 20 . 0	.2,0.,2000
		Clinical Review to avoid post-service review.		
L8612	Aqueous shunt	MP Criteria: Procedure/service reviewed against	7/1/2014	12/31/2999
	, 1945555 5.14.11	Medical Policy Criteria. Submit for Recommended	.,.,	12/01/2000
		Clinical Review to avoid post-service review.		
L8678	Electrical stimulator supplies (external) for use with implantable	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
200.0	neurostimulator, per month	Medical Policy Criteria. Submit for Recommended	1710/2020	12/01/2000
	nourosumulator, per month	Clinical Review to avoid post-service review.		
L8679	Implantable neurostimulator, pulse generator, any type	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
L0073	implantable hedrostimulator, pulse generator, arry type	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/01/2000
		Clinical Review to avoid post-service review.		
L8680	Implantable neurostimulator electrode, each	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
LUUUU	implantable fleurosumulator electrode, each	Medical Policy Criteria. Submit for Recommended	1/ 1/2022	12/01/2000
		Clinical Review to avoid post-service review.		
1 0601	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
L8681		_	111012023	12/31/2999
	IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE	Medical Policy Criteria. Submit for Recommended		
	GENERATOR, REPLACEMENT ONLY	Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8682	Implantable neurostimulator radiofrequency receiver	MP Criteria: Procedure/service reviewed against	9/19/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8683	Radiofrequency transmitter (external) for use with implantable	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	neurostimulator radiofrequency receiver	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8685	Implantable neurostimulator pulse generator, single array, rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	includes extension	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8686	Implantable neurostimulator pulse generator, single array, non-	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
20000	rechargeable, includes extension	Medical Policy Criteria. Submit for Recommended	17 172022	12/01/2000
	Tooliargoable, morages extension	Clinical Review to avoid post-service review.		
_8687	Implantable neurostimulator pulse generator, dual array, rechargeable,	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
_0007	includes extension	Medical Policy Criteria. Submit for Recommended	1/1/2022	12/31/2999
	Illiciades exterision	Clinical Review to avoid post-service review.		
L8688	Implantable neurostimulator pulse generator, dual array, non-	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
_0000	· · ·	•	1/1/2022	12/31/2999
	rechargeable, includes extension	Medical Policy Criteria. Submit for Recommended		
2000	EVERNAL PROMERCIAL SON DATES AND THE PARTY OF THE PARTY O	Clinical Review to avoid post-service review.	7/45/0000	40/04/0000
_8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR	MP Criteria: Procedure/service reviewed against	7/15/2023	12/31/2999
	USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT	Medical Policy Criteria. Submit for Recommended		
	ONLY	Clinical Review to avoid post-service review.		
_8694	Auditory osseointegrated device, transducer/actuator, replacement only,	MP Criteria: Procedure/service reviewed against	1/1/2018	12/31/2999
	each	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR	MP Criteria: Procedure/service reviewed against	9/19/2022	12/31/2999
	USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT	Medical Policy Criteria. Submit for Recommended		
	ONLY	Clinical Review to avoid post-service review.		
_8698	Miscellaneous component, supply or accessory for use with total artificial	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	heart system	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
_8701	Powered upper extremity range of motion assist device, elbow, wrist,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
	hand with single or double upright(s), includes microprocessor, sensors,	Medical Policy Criteria. Submit for Recommended		
	all components and accessories, custom fabricated	Clinical Review to avoid post-service review.		
_8702	Powered upper extremity range of motion assist device, elbow, wrist,	MP Criteria: Procedure/service reviewed against	1/1/2019	12/31/2999
-0.02	hand, finger, single or double upright(s), includes microprocessor,	Medical Policy Criteria. Submit for Recommended	17 172010	12/01/2000
	sensors, all components and accessories, custom fabricated	Clinical Review to avoid post-service review.		
M0075	Cellular therapy	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
VIOO7 5	Condian thorapy	Plan. Not subject to pre-service review.	1/1/1550	12/01/2000
M0100	Intragastric hypothermia using gastric freezing	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
VIO 100	intragastric hypotherma using gastric freezing	•	1/1/1930	12/31/2999
110200	ly shelation therepy (shemical anderters stars)	Plan. Not subject to pre-service review.	1/1/1050	12/21/2000
M0300	lv chelation therapy (chemical endarterectomy)	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
110001		Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
M0301	Fabric wrapping of abdominal aneurysm	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
P2029	Congo red, blood	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car	MP Criteria: Procedure/service reviewed against	4/1/2018	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including	MP Criteria: Procedure/service reviewed against	7/1/2011	12/31/2999
	leukapheresis and dose preparation procedures, per therapeutic dose	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q2049	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	Non Covered: Procedure/service not covered by the	4/1/2024	12/31/2999
		Plan. Not subject to pre-service review.		
Q2052	Services, supplies, and accessories used in the home for the	Non Covered: Procedure/service not covered by the	4/1/2014	12/31/2999
	administration of intravenous immune globulin (ivig)	Plan. Not subject to pre-service review.		
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car	MP Criteria: Procedure/service reviewed against	4/1/2021	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-	MP Criteria: Procedure/service reviewed against	10/1/2021	12/31/2999
	positive viable t cells, including leukapheresis and dose preparation	Medical Policy Criteria. Submit for Recommended		
	procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation	MP Criteria: Procedure/service reviewed against	1/1/2022	12/31/2999
	antigen (bcma) directed car-positive t cells, including leukapheresis and	Medical Policy Criteria. Submit for Recommended		
	dose preparation procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation	MP Criteria: Procedure/service reviewed against	10/1/2022	12/31/2999
	antigen (bcma) directed car-positive t cells, including leukapheresis and	Medical Policy Criteria. Submit for Recommended		
	dose preparation procedures, per therapeutic dose	Clinical Review to avoid post-service review.		
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B	Non Covered: Procedure/service not covered by the	1/1/2007	12/31/2999
	DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Plan. Not subject to pre-service review.		
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4101	APLIGRAF, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4102	OASIS WOUND MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
	,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
	regeneration matrix, per square centimeter	Medical Policy Criteria. Submit for Recommended		
	Togonoration matrix, per oquare continuetor	Clinical Review to avoid post-service review.		
Q4106	DERMAGRAFT, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q.1.00		Medical Policy Criteria. Submit for Recommended		. = / 0 . / = 000
		Clinical Review to avoid post-service review.		
Q4107	GRAFTJACKET, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q1101	OTAL TOTORET, TERROGOTHE SERVINGTER	Medical Policy Criteria. Submit for Recommended	11/10/2020	12/01/2000
		Clinical Review to avoid post-service review.		
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Q+100	THE COUNTY OF TH	Medical Policy Criteria. Submit for Recommended	11/10/2020	12/01/2000
		Clinical Review to avoid post-service review.		
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
Ψ 1114	INTEGRATEOVADLE WOUND WATRIA, INJECTABLE, TOO	Medical Policy Criteria. Submit for Recommended	1 1/ 13/2020	12/31/2333
	1	Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4116	ALLODERM, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4121	THERASKIN, PER SQUARE CENTIMETER	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square	MP Criteria: Procedure/service reviewed against	10/15/2021	12/31/2999
	centimeter	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4128	Flex hd, or allopatch hd, per square centimeter	MP Criteria: Procedure/service reviewed against	11/15/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4132	Grafix core and grafixpl core, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4151	Amnioband or guardian, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4154	Biovance, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4159	Affinity, per square centimeter	MP Criteria: Procedure/service reviewed against	2/1/2022	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4168	Amnioband, 1 mg	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
	, ,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4186	Epifix, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4187	Epicord, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2021	12/31/2999
Q1101	Episora, por oquare continuous	Medical Policy Criteria. Submit for Recommended	0/10/2021	12/01/2000
		Clinical Review to avoid post-service review.		
Q4283	Biovance tri-layer or biovance 3I, per square centimeter	MP Criteria: Procedure/service reviewed against	8/15/2023	12/31/2999
Q 1200	Biotalise at layer or biotalise of, per equal contained	Medical Policy Criteria. Submit for Recommended	0/10/2020	12/01/2000
		Clinical Review to avoid post-service review.		
Q4304	Grafix plus, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2024	12/31/2999
∝ -00 -	Orana pius, per square continuctor	Medical Policy Criteria. Submit for Recommended	0, 10,2027	12/01/2000
		Clinical Review to avoid post-service review.	1	
Q4334	Amnioplast 1, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
Q 4 004	Aminopiasi i, per square centimeter	Š	2/13/2023	3/ 14/2023
		Medical Policy Criteria. Submit for Recommended	1	
	<u> </u>	Clinical Review to avoid post-service review.		1

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4335	Amnioplast 2, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4336	Artacent c, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4337	Artacent trident, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4338	Artacent velos, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4339	Artacent vericlen, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4340	Simpligraft, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4341	Simplimax, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
Q.0	ompinios, por oquais commission	Medical Policy Criteria. Submit for Recommended	2, 10, 2020	0, 1 1, 2020
		Clinical Review to avoid post-service review.		
Q4342	Theramend, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
~ · · · · ·	Thoramona, por equal e commeter	Medical Policy Criteria. Submit for Recommended	2, 10, 2020	67 1 17 20 20
		Clinical Review to avoid post-service review.		
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
Q 10 10	Bornadyte ad matrix amment membrane anogram, per equale continues	Medical Policy Criteria. Submit for Recommended	2, 10, 2020	0/11/2020
		Clinical Review to avoid post-service review.		
Q4344	Tri-membrane wrap, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
Q-10-1-1	The monitoriane wap, per square continues	Medical Policy Criteria. Submit for Recommended	2/10/2020	0/14/2020
		Clinical Review to avoid post-service review.		
Q4345	Matrix hd allograft dermis, per square centimeter	MP Criteria: Procedure/service reviewed against	2/15/2025	5/14/2025
Q+0+0	Matrix na anografit donnio, por oquare continuotor	Medical Policy Criteria. Submit for Recommended	2/10/2020	0/14/2020
		Clinical Review to avoid post-service review.		
Q4346	Shelter dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
Q4340	Official diff matrix, per square certainleter	Medical Policy Criteria. Submit for Recommended	3/13/2023	12/31/2999
		Clinical Review to avoid post-service review.		
Q4347	Rampart dl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
Q4541	Trampart di matrix, per square centimeter	Medical Policy Criteria. Submit for Recommended	3/13/2023	12/31/2999
		Clinical Review to avoid post-service review.		
Q4348	Sentry sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
Q4346	Sentry Si matrix, per square centimeter	•	3/13/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
Q4349	Montle di matriy, per aguare contimeter	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against	3/15/2025	12/21/2000
Q4349	Mantle dl matrix, per square centimeter	•	3/13/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
0.4050	Delite de des matris accompany of Control	Clinical Review to avoid post-service review.	0.45.0005	40/04/0000
Q4350	Palisade dm matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4351	Enclose tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4352	Overlay sl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q4353	Xceed tl matrix, per square centimeter	MP Criteria: Procedure/service reviewed against	3/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5106	Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000	MP Criteria: Procedure/service reviewed against	4/15/2020	12/31/2999
	units	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	MP Criteria: Procedure/service reviewed against	10/1/2020	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against	8/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against	7/1/2024	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	MP Criteria: Procedure/service reviewed against	2/15/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	7/15/2024	12/31/2999
	[,,,, (<u>-</u>),,	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
Q0001	[, Joseph, Lotermanias and (p)_5, a,,	Medical Policy Criteria. Submit for Recommended	07.172020	1.2,01,2000
		Clinical Review to avoid post-service review.		
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg	MP Criteria: Procedure/service reviewed against	3/1/2025	12/31/2999
40000	injection, determinable down (boldroar), 1 mg	Medical Policy Criteria. Submit for Recommended	0/ 1/2020	12/01/2000
		Clinical Review to avoid post-service review.		
S0013	Esketamine, nasal spray, 1 mg	MP Criteria: Procedure/service reviewed against	2/1/2021	12/31/2999
50010	Londamino, masar spray, 1 mg	Medical Policy Criteria. Submit for Recommended	2/1/2021	12/01/2000
		Clinical Review to avoid post-service review.		
S0117	Tretinoin, topical, 5 grams	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
30117	Treunom, opical, o grams	Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
S0142	COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED		4/1/2005	12/31/2999
JU 174	THROUGH DME, CONCENTRATED FORM, PER MG	Plan. Not subject to pre-service review.	7/1/2003	12/3/1/2333
S0197	PRENATAL VITAMINS, 30-DAY SUPPLY	Non Covered: Procedure/service not covered by the	4/1/2005	12/31/2999
30191	FINEINATAL VITAIVIIINO, JU-DAT SUFFLT	Plan. Not subject to pre-service review.	4/1/2003	12/31/2999
S0207	Paramedic intercept, non-hospital-based als service (non-voluntary), non-		1/1/1950	12/31/2999
30201			1/1/1950	12/31/2999
S0209	transport	Plan. Not subject to pre-service review.	1/1/2021	12/31/2999
50209	Wheelchair van, mileage, per mile	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0215	Non-emergency transportation; mileage, per mile	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S0320	Telephone calls by a registered nurse to a disease management program	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	member for monitoring purposes; per month	Plan. Not subject to pre-service review.		
S0800	Laser in situ keratomileusis (lasik)	Non Covered: Procedure/service not covered by the	11/1/2011	12/31/2999
		Plan. Not subject to pre-service review.		
S0810	Photorefractive keratectomy (prk)	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
S2102	Islet cell tissue transplant from pancreas; allogeneic	MP Criteria: Procedure/service reviewed against	11/15/2023	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2103	Adrenal tissue transplant to brain	MP Criteria: Procedure/service reviewed against	11/1/2019	12/31/2999
	·	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2107	Adoptive immunotherapy i. E. Development of specific anti-tumor	MP Criteria: Procedure/service reviewed against	2/1/2025	12/31/2999
	reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of	Medical Policy Criteria. Submit for Recommended		
	treatment	Clinical Review to avoid post-service review.		
S2118	Metal-on-metal total hip resurfacing, including acetabular and femoral	MP Criteria: Procedure/service reviewed against	10/1/2008	12/31/2999
	components	Medical Policy Criteria. Submit for Recommended		1-1-1-1-1-1
		Clinical Review to avoid post-service review.		
S2140	Cord blood harvesting for transplantation, allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
	on a zhou hai vouing for a anophantanon, amogonolo	Medical Policy Criteria. Submit for Recommended		12/01/2000
		Clinical Review to avoid post-service review.		
S2142	Cord blood-derived stem-cell transplantation, allogeneic	MP Criteria: Procedure/service reviewed against	2/1/2013	12/31/2999
02112	Cord blood defit of transplantation, allogonolo	Medical Policy Criteria. Submit for Recommended	27 1720 10	12/01/2000
		Clinical Review to avoid post-service review.		
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical),	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
02100	allogeneic or autologous, harvesting, transplantation, and related	Medical Policy Criteria. Submit for Recommended	17 17 1000	12/01/2000
	complications; including: pheresis and cell preparation/storage; marrow	Clinical Review to avoid post-service review.		
	ablative therapy; drugs, supplies, hospitalization with outpatient follow-up;	Cililical Neview to avoid post-service review.		
	medical/surgical, diagnostic, emergency, and rehabilitative services; and			
	the number of days of pre-and post-transplant care in the global definition			
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed against	9/24/2012	12/31/2999
SZZOZ	Lonosocioniciapy	Medical Policy Criteria. Submit for Recommended	3/24/2012	12/01/2000
		Clinical Review to avoid post-service review.		
S2230	Implantation of magnetic component of semi-implantable hearing device	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
32230	on ossicles in middle ear	Medical Policy Criteria. Submit for Recommended	1/1/1930	12/31/2999
	on ossicles in middle ear	Clinical Review to avoid post-service review.		
S2400	Repair, congenital diaphragmatic hernia in the fetus using temporary	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
32400	tracheal occlusion, procedure performed in utero	Medical Policy Criteria. Submit for Recommended	10/1/2023	12/31/2999
	tracheal occlusion, procedure periormed in diero			
S2401	Repair, urinary tract obstruction in the fetus, procedure performed in utero	Clinical Review to avoid post-service review.	10/1/2023	12/31/2999
32401	repair, unitiary tract obstruction in the letus, procedure performed in utero	_	10/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
00400	Danain assumantial quatic adamamentation of forms of the first	Clinical Review to avoid post-service review.	40/4/2022	40/04/0000
S2402	Repair, congenital cystic adenomatoid malformation in the fetus,	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	procedure performed in utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2403	Repair, extralobar pulmonary sequestration in the fetus, procedure	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
	performed in utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2404	Repair, myelomeningocele in the fetus, procedure performed in utero	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in	MP Criteria: Procedure/service reviewed against	11/1/2012	12/31/2999
	utero	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2409	Repair, congenital malformation of fetus, procedure performed in utero,	MP Criteria: Procedure/service reviewed against	10/1/2023	12/31/2999
	not otherwise classified	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion	MP Criteria: Procedure/service reviewed against	12/1/2022	12/31/2999
	syndrome	Medical Policy Criteria. Submit for Recommended		
	'	Clinical Review to avoid post-service review.		
S3600	Stat laboratory request (situations other than s3601)	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Plan. Not subject to pre-service review.		
S3601	Emergency stat laboratory charge for patient who is homebound or	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	residing in a nursing facility	Plan. Not subject to pre-service review.	., .,	12/01/2000
S4026	Procurement of donor sperm from sperm bank	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0 1020	Treadistrict of densi openii from openii bariik	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S4027	Storage of previously frozen embryos	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04021	otorago or proviously mozem ombi you	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
S4030	Sperm procurement and cryopreservation services; initial visit	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04000	openii procurement and dryopreservation services, initial visit	Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
S4031	Sperm procurement and cryopreservation services; subsequent visit	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04001	openii procurement and dryopreservation services, subsequent visit	Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
S4040	Monitoring and storage of cryopreserved embryos, per 30 days	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04040	informating and storage of dryopreserved embryos, per 50 days	Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
S4990	Nicotine patches, legend	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0-330	Tricotine pateries, regend	Plan. Not subject to pre-service review.	17 17 1330	12/01/2000
S4991	Nicotine patches, non-legend	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
04991	Nicotine pateries, non-legend	Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
34993	Shloking Cessation guill	Plan. Not subject to pre-service review.	1/1/1930	12/31/2999
S5100	Day care services, adult; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
33100	Day care services, addit, per 13 minutes		1/1/1930	12/31/2999
S5101	Day care services, adult; per half day	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
33101	Day care services, adult, per fiall day		1/1/1930	12/31/2999
S5102	Day care services, adult; per diem	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
35102	Day care services, adult, per diem		1/1/1950	12/31/2999
05405	Day and admired and hazardy admired makingly de discourse for	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
S5105	Day care services, center-based; services not included in program fee,	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
05400	per diem	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
S5108	Home care training to home care client, per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
S5109	Home care training to home care client, per session	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

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	1/1/1950	12/31/2999
S5111	Home care training family nor acceion	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
00111	Home care training, family; per session	·	1/1/1950	12/31/2999
5115	Home care training non-family, nor 15 minutes	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1050	10/04/0000
0110	Home care training, non-family; per 15 minutes	•	1/1/1950	12/31/2999
5116	Llama cara training, non family, nor accaion	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0110	Home care training, non-family; per session	•	1/1/1950	12/31/2999
5120	Chore services; per 15 minutes	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
5120	Chore services; per 15 minutes		1/1/1950	12/31/2999
E404	Observation and the second sec	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
5121	Chore services; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
5405	Au 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
5125	Attendant care services; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	4444050	10/04/0000
5126	Attendant care services; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
55130	Homemaker service, nos; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5131	Homemaker service, nos; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5135	Companion care, adult (e. G. ladl/adl); per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5136	Companion care, adult (e. G. ladl/adl); per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5140	Foster care, adult; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5141	Foster care, adult; per month	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5145	Foster care, therapeutic, child; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5146	Foster care, therapeutic, child; per month	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5150	Unskilled respite care, not hospice; per 15 minutes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5151	Unskilled respite care, not hospice; per diem	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
5160	Emergency response system; installation and testing	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.	., .,	
5161	Emergency response system; service fee, per month (excludes	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0101	installation and testing)	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
5162	Emergency response system; purchase only	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0102	Emergency response system, purchase only	Plan. Not subject to pre-service review.	17 17 1000	12/01/2000
 5165	Home modifications; per service	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
0100	nome mounications, per service	·	1/1/1950	12/3/1/2333
5170	Home delivered meals, including preparation; per meal	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
3170	Home delivered meals, including preparation; per meal		1/1/1950	12/31/2999
5175	Loundry convine external professional per ender	Plan. Not subject to pre-service review.	1/1/1950	12/31/2999
0170	Laundry service, external, professional; per order	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		

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	4/1/2009	12/31/2999
S8040	Topographic brain mapping	Clinical Review to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended	3/1/2024	12/31/2999
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Clinical Review to avoid post-service review. 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 reviewd 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	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
/2219	Bifocal seg width over 28mm	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2600	Hand held low vision aids and other nonspectacle mounted aids	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2610	Single lens spectacle mounted low vision aids	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2615	Telescopic and other compound lens system, including distance vision	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
	telescopic, near vision telescopes and compound microscopic lens	Plan. Not subject to pre-service review.		
	system			
/2627	Scleral cover shell	MP Criteria: Procedure/service reviewed against	5/15/2016	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review.		
/2702	DELUXE LENS FEATURE	Non Covered: Procedure/service not covered by the	1/1/2021	12/31/2999
		Plan. Not subject to pre-service review.		
/2715	Prism, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2718	Press-on lens, fresnell prism, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2730	Special base curve, glass or plastic, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2744	Tint, photochromatic, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
V2750	Anti-reflective coating, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2755	U-v lens, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2760	Scratch resistant coating, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2770	Occluder lens, per lens	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
		Plan. Not subject to pre-service review.		
/2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10700		Clinical Review to avoid post-service review.	1011510000	40/04/0000
/2788	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	MP Criteria: Procedure/service reviewed against	10/15/2008	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
10700		Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
/2799	Vision item or service, miscellaneous	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
/F00F	O and describe and all a second and a second and a second	Plan. Not subject to pre-service review.	4/4/4050	40/04/0000
/5095	Semi-implantable middle ear hearing prosthesis	MP Criteria: Procedure/service reviewed against	1/1/1950	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
15004	Describe and a second of the s	Clinical Review to avoid post-service review.	4/4/4050	40/04/0000
/5364	Dysphagia screening	Non Covered: Procedure/service not covered by the	1/1/1950	12/31/2999
20522		Plan. Not subject to pre-service review.	40/4/0000	10/04/0000
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Non Covered: Procedure/service not covered by the	12/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22868	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	device, without fusion, including image guidance when performed, with	Not subject to pre-service review. Check EIU policy,		
	open decompression, lumbar; second level (List separately in addition to	which is one of our Clinical Payment and Coding		
	code for primary procedure)	Policy (CPCP).		
22868	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2017	12/31/2018
	device without fusion including image guidance when performed with	Not subject to pre-service review. Check EIU policy,		
	open decompression lumbar; second level (List separately in addition to	which is one of our Clinical Payment and Coding		
	code for primary procedure)	Policy (CPCP).		
22869	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	device, without open decompression or fusion, including image guidance	Not subject to pre-service review. Check EIU policy,		
	when performed, lumbar; single level	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
22869	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2017	12/31/2018
	device without open decompression or fusion including image guidance	Not subject to pre-service review. Check EIU policy,		
	when performed lumbar; single level	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
22870	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	device, without open decompression or fusion, including image guidance	Not subject to pre-service review. Check EIU policy,		
	when performed, lumbar; second level (List separately in addition to code	which is one of our Clinical Payment and Coding		
	for primary procedure)	Policy (CPCP).		
22870	Insertion of interlaminar/interspinous process stabilization/distraction	EIU: Procedure/service not reimbursed by the Plan.	1/1/2017	12/31/2018
	device without open decompression or fusion including image guidance	Not subject to pre-service review. Check EIU policy,		
	when performed lumbar; second level (List separately in addition to code	which is one of our Clinical Payment and Coding		
	for primary procedure)	Policy (CPCP).		
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	placement of intra-articular implant(s) (eg, bone allograft[s], synthetic	Not subject to pre-service review. Check EIU policy,		
	device[s]), without placement of transfixation device	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	implant(s)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	radiofrequency) subcutaneous/submucosal remodeling	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	ablation, posterior nasal nerve	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	posterior nasal nerve	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
33276	Insertion of phrenic nerve stimulator system (pulse generator and	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
JUL. 0	stimulating lead[s]), including vessel catheterization, all imaging guidance,		0, 10/2021	.2/01/2000
		· · · · · · · · · · · · · · · · · · ·		
	and pulse generator initial analysis with diagnostic mode activation, when	which is one of our Clinical Payment and Coding		

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 quidance 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 quidance 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	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	endomicroscopy	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intragastric bariatric balloon	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
13291	Esophagogastroduodenoscopy, flexible, transoral; with removal of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intragastric bariatric balloon(s)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
16707	Repair of anorectal fistula with plug (eg, porcine small intestine	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	submucosa [SIS])	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
52284	Cystourethroscopy, with mechanical urethral dilation and urethral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	therapeutic drug delivery by drug-coated balloon catheter for urethral	Not subject to pre-service review. Check EIU policy,		
	stricture or stenosis, male, including fluoroscopy, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53451	Periurethral transperineal adjustable balloon continence device; bilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53452	Periurethral transperineal adjustable balloon continence device; unilateral	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	insertion, including cystourethroscopy and imaging guidance	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53453	Periurethral transperineal adjustable balloon continence device; removal,	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	each balloon	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53454	Periurethral transperineal adjustable balloon continence device;	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	percutaneous adjustment of balloon(s) fluid volume	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53855	Insertion of a temporary prostatic urethral stent, including urethral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	measurement	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53855	Insertion of a temporary prostatic urethral stent including urethral	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	10/14/2020
	measurement	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
53855	Insertion of a temporary prostatic urethral stent including urethral	EIU: Procedure/service not reimbursed by the Plan.	12/15/2014	10/31/2019
	measurement	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
53860	Transurethral radiofrequency micro-remodeling of the female bladder	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	neck and proximal urethra for stress urinary incontinence	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis),	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	percutaneous	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	1/31/2025
	separately in addition to code for primary procedure)	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
62263	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 2 or more days	Policy (CPCP).		
62264	Percutaneous lysis of epidural adhesions using solution injection (eg,	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	hypertonic saline, enzyme) or mechanical means (eg, catheter) including	Not subject to pre-service review. Check EIU policy,		
	radiologic localization (includes contrast when administered), multiple	which is one of our Clinical Payment and Coding		
	adhesiolysis sessions; 1 day	Policy (CPCP).		
62287	Decompression procedure, percutaneous, of nucleus pulposus of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	intervertebral disc, any method utilizing needle based technique to	Not subject to pre-service review. Check EIU policy,		
	remove disc material under fluoroscopic imaging or other form of indirect	which is one of our Clinical Payment and Coding		
	visualization, with discography and/or epidural injection(s) at the treated	Policy (CPCP).		
	level(s), when performed, single or multiple levels, lumbar	1 5115) (51 51).		
62287	Decompression procedure percutaneous of nucleus pulposus of	EIU: Procedure/service not reimbursed by the Plan.	9/15/2016	10/31/2019
	intervertebral disc any method utilizing needle based technique to	Not subject to pre-service review. Check EIU policy,		
	remove disc material under fluoroscopic imaging or other form of indirect	which is one of our Clinical Payment and Coding		
	visualization with discography and/or epidural injection(s) at the treated	Policy (CPCP).		
	level(s) when performed single or multiple levels lumbar	1 only (of of).		
64628	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
04020	imaging guidance; first 2 vertebral bodies, lumbar or sacral	Not subject to pre-service review. Check EIU policy,	0/1/2022	12/01/2000
	intaging guidance, mat 2 vertebral bodies, fumbal of sacral	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
64629	Thermal destruction of intraosseous basivertebral nerve, including all	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
04023	imaging guidance; each additional vertebral body, lumbar or sacral (List	Not subject to pre-service review. Check EIU policy,	0/1/2022	12/31/2999
	separately in addition to code for primary procedure)	which is one of our Clinical Payment and Coding		
	Separately in addition to code for primary procedure)	Policy (CPCP).		
82523	Collagen cross links, any method	Non Covered: Procedure/service not covered by the	12/15/2014	12/31/2999
02323	Collage I Closs Illiks, ally filetilod	Plan. Not subject to pre-service review.	12/13/2014	12/31/2999
83695	Lipoprotein (a)	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
00080	μιροριοισίι (α)	•	3/1/2020	12/3/1/2999
92609	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	0/1/2020	12/21/2000
83698	Lipoprotein-associated phospholipase AZ (Lp-PLAZ)	•	9/1/2020	12/31/2999
02704	Lineariate bloods high recolution frontier attended according to the	Plan. Not subject to pre-service review.	0/4/2020	10/21/2000
83701	Lipoprotein, blood; high resolution fractionation and quantitation of	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
	lipoproteins including lipoprotein subclasses when performed (eg,	Plan. Not subject to pre-service review.		
	electrophoresis, ultracentrifugation)			

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		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.	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,	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
0339Т	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed: bilateral	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2023
	central sleep apnea pulse generator only	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0432T	Repositioning of neurostimulator system for treatment of central sleep	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2023
	apnea; stimulation lead only	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0433T	Repositioning of neurostimulator system for treatment of central sleep	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2023
	apnea; sensing lead only	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0434T	Interrogation device evaluation implanted neurostimulator pulse generator		4/1/2022	12/31/2023
	system for central sleep apnea	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0435T	Programming device evaluation of implanted neurostimulator pulse	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2023
	generator system for central sleep apnea; single session	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0436T	Programming device evaluation of implanted neurostimulator pulse	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2023
	generator system for central sleep apnea; during sleep study	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2022
	including fitting training and insertion unilateral or bilateral	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0445T	Subsequent placement of a drug-eluting ocular insert under one or more	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2022
	eyelids including re-training and removal of existing insert unilateral or	Not subject to pre-service review. Check EIU policy,		
	bilateral	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0499T	Cystourethroscopy with mechanical dilation and urethral therapeutic drug		12/1/2020	12/31/2023
	delivery for urethral stricture or stenosis including fluoroscopy when	Not subject to pre-service review. Check EIU policy,		
	performed	which is one of our Clinical Payment and Coding		
25117		Policy (CPCP).	40/4/0000	10/01/0000
0511T	Removal and reinsertion of sinus tarsi implant	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
2500T		Policy (CPCP).	40/4/0000	10/01/0000
0533T	Continuous recording of movement disorder symptoms including	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2023
	bradykinesia dyskinesia and tremor for 6 days up to 10 days; includes	Not subject to pre-service review. Check EIU policy,		
	set-up patient training configuration of monitor data upload analysis	which is one of our Clinical Payment and Coding		
0504T	and initial report configuration download review interpretation and report		40/4/0000	40/04/0000
0534T	Continuous recording of movement disorder symptoms including	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2023
	bradykinesia dyskinesia and tremor for 6 days up to 10 days; set-up	Not subject to pre-service review. Check EIU policy,		
	patient training configuration of monitor	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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.	1/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0623T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		
	computed tomographic angiography; data preparation and transmission,	which is one of our Clinical Payment and Coding		
	computerized analysis of data, with review of computerized analysis	Policy (CPCP).		
	output to reconcile discordant data, interpretation and report			
0624T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		
	computed tomographic angiography; data preparation and transmission	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0625T	Automated quantification and characterization of coronary atherosclerotic	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021 12/31/2999	12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		
	computed tomographic angiography; computerized analysis of data from	which is one of our Clinical Payment and Coding		
	coronary computed tomographic angiography	Policy (CPCP).		
0626T	Automated quantification and characterization of coronary atherosclerotic		1/1/2021	12/31/2999
	plaque to assess severity of coronary disease, using data from coronary	Not subject to pre-service review. Check EIU policy,		
	computed tomographic angiography; review of computerized analysis	which is one of our Clinical Payment and Coding		
	output to reconcile discordant data, interpretation and report	Policy (CPCP).		
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,		
	guidance, lumbar; first level	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product,		1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with fluoroscopic	Not subject to pre-service review. Check EIU policy,		
	guidance, lumbar; each additional level (List separately in addition to code			
	for primary procedure)	Policy (CPCP).		
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	•	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,		
	lumbar; first level	which is one of our Clinical Payment and Coding		
2002		Policy (CPCP).	4/4/0004	10/04/0000
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	intervertebral disc, unilateral or bilateral injection, with CT guidance,	Not subject to pre-service review. Check EIU policy,		
	lumbar; each additional level (List separately in addition to code for	which is one of our Clinical Payment and Coding		
0004T	primary procedure)	Policy (CPCP).	4/4/0004	40/04/0000
0631T	Transcutaneous visible light hyperspectral imaging measurement of	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with	Not subject to pre-service review. Check EIU policy,		
	interpretation and report, per extremity	which is one of our Clinical Payment and Coding		
0000T	Describer and the second behavior of the second and the second se	Policy (CPCP).	4/4/0004	0/20/2022
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	6/30/2023
	pulmonary arteries including right heart catheterization pulmonary artery	Not subject to pre-service review. Check EIU policy,		
	angiography and all imaging guidance	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0639T	Wireless skin sensor thermal anisotropy measurement(s) and	EIU: Procedure/service not reimbursed by the Plan.	1/1/2021	12/31/2999
	assessment of flow in cerebrospinal fluid shunt, including ultrasound	Not subject to pre-service review. Check EIU policy,		
	guidance, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0640T	Noncontact near-infrared spectroscopy (eg, for measurement of	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2999
	deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other	Not subject to pre-service review. Check EIU policy,		
	than for screening for peripheral arterial disease, image acquisition,	which is one of our Clinical Payment and Coding		
	interpretation, and report; first anatomic site	Policy (CPCP).		
0641T	Noncontact near-infrared spectroscopy studies of flap or wound (eg for	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2023
	measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue	Not subject to pre-service review. Check EIU policy,		
	oxygenation [StO2]); image acquisition only each flap or wound	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0642T	Noncontact near-infrared spectroscopy studies of flap or wound (eg for	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2023
	measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue	Not subject to pre-service review. Check EIU policy,		
	oxygenation [StO2]); interpretation and report only each flap or wound	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach,	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
	including intraprocedural positioning of capsule, with interpretation and	Not subject to pre-service review. Check EIU policy,		
	report	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2999
	vertebral segments	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more	EIU: Procedure/service not reimbursed by the Plan.	7/1/2021	12/31/2999
	vertebral segments	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0664T	Donor hysterectomy (including cold preservation); open, from cadaver	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	donor	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0665T	Donor hysterectomy (including cold preservation); open, from living donor		8/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic,	, , , , , , , , , , , , , , , , , , , ,	8/15/2021	12/31/2999
	from living donor	Not subject to pre-service review. Check EIU policy,		1-1-1-1-1-1-1
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0667T	Donor hysterectomy (including cold preservation); recipient uterus	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	allograft transplantation from cadaver or living donor	Not subject to pre-service review. Check EIU policy,		
	and grant transplantation from outdayor or fiving donor	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0668T	Backbench standard preparation of cadaver or living donor uterine	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
00001	allograft prior to transplantation, including dissection and removal of	Not subject to pre-service review. Check EIU policy,	0/10/2021	12/01/2000
	surrounding soft tissues and preparation of uterine vein(s) and uterine	which is one of our Clinical Payment and Coding		
	· · ·			
	artery(ies), as necessary	Policy (CPCP).		

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		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
0769Т	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		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	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	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	measurement of evoked cortical potentials with automated report	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0864T	Low-intensity extracorporeal shock wave therapy involving corpus	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	cavernosum, low energy	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0870T	Implantation of subcutaneous peritoneal ascites pump system,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	percutaneous, including pump-pocket creation, insertion of tunneled	Not subject to pre-service review. Check EIU policy,		
	indwelling bladder and peritoneal catheters with pump connections,	which is one of our Clinical Payment and Coding		
	including all imaging and initial programming, when performed	Policy (CPCP).		
)871T	Replacement of a subcutaneous peritoneal ascites pump, including	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	reconnection between pump and indwelling bladder and peritoneal	Not subject to pre-service review. Check EIU policy,		
	catheters, including initial programming and imaging, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0872T	Replacement of indwelling bladder and peritoneal catheters, including	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	tunneling of catheter(s) and connection with previously implanted	Not subject to pre-service review. Check EIU policy,		
	peritoneal ascites pump, including imaging and programming, when	which is one of our Clinical Payment and Coding		
	performed	Policy (CPCP).		
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	any component (ascites pump, associated peritoneal catheter, associated	Not subject to pre-service review. Check EIU policy,		
	bladder catheter), including imaging and programming, when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0874T	Removal of a peritoneal ascites pump system, including implanted	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	peritoneal ascites pump and indwelling bladder and peritoneal catheters	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
0875T	Programming of subcutaneously implanted peritoneal ascites pump	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	system by physician or other qualified health care professional	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2001	Innovamatrix ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2002	Mirragen advanced wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2004	Xcellistem, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2005	Microlyte matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2006	Novosorb synpath dermal matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2007	Restrata, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2008	Theragenesis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2009	Symphony, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2010	Apis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/15/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2011	Supra sdrm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2012	Suprathel, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2013	Innovamatrix fs, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2014	Omeza collagen matrix, per 100 mg	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2015	Phoenix wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2016	Permeaderm b, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
	, , , , , , , , , , , , , , , , , , , ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2017	Permeaderm glove, each	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
	. Simoddonin gioro, oddin	Not subject to pre-service review. Check EIU policy,		, 0 1/2000
		which is one of our Clinical Payment and Coding		
		,		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2018	Permeaderm c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
N2019	Kerecis omega3 marigen shield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2020	Ac5 advanced wound system (ac5)	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2021	Neomatrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2022	Innovaburn or innovamatrix xl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
A2023	Innovamatrix pd, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2024	Resolve matrix or xenopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2025	Miro3d, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2026	Restrata minimatrix, 5 mg	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
2027	Matriderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2028	Micromatrix flex, per mg	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	,,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\2029	Mirotract wound matrix sheet, per cubic centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	, , ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	nerves of the upper arm	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\4542	Supplies and accessories for external upper limb tremor stimulator of the		5/15/2024	12/31/2999
	peripheral nerves of the wrist	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
N4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	auricular region, per month	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only	EIU: Procedure/service not reimbursed by the Plan.	1/15/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\4596	Cranial electrotherapy stimulation (ces) system supplies and accessories	EIU: Procedure/service not reimbursed by the Plan.	4/1/2023	12/31/2999
	per month	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\7021	Supplies and accessories for lung expansion airway clearance,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	continuous high frequency oscillation, and nebulization device (e.g.,	Not subject to pre-service review. Check EIU policy,		
	handset, nebulizer kit, biofilter)	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\7049	Expiratory positive airway pressure intranasal resistance valve	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\9285	Inversion/eversion correction device	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
\9291	Prescription digital cognitive and/or behavioral therapy fda cleared per	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	1/31/2024
	course of treatment	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1052	Hemostatic agent, gastrointestinal, topical	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1823	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
	transvenous sensing and stimulation leads	Not subject to pre-service review. Check EIU policy,		
	and the second s	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C1827	Generator, neurostimulator (implantable), non-rechargeable, with	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	implantable stimulation lead and external paired stimulation controller	Not subject to pre-service review. Check EIU policy,	0, ., 1020	, 0 1/2000
	Implantable definition load and external paired stimulation controller			
		which is one of our Clinical Payment and Coding Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
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	5/15/2024	12/31/2999
		Policy (CPCP).		
C9354	Acellular pericardial tissue matrix of non-human origin (Veritas), per	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	square centimeter	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	matrix (TenoGlide Tendon Protector Sheet), per square centimeter	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	(SurgiMend Collagen Matrix), per 0.5 square centimeters	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
00000		Policy (CPCP).	40/4/0000	40/04/0000
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	(SurgiMend Collagen Matrix), per 0.5 square centimeters	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding Policy (CPCP).		
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
09303	centimeter	Not subject to pre-service review. Check EIU policy,	3/13/2021	12/31/2999
	Continuetor	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9364	Porcine implant, Permacol, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s),	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
	including partial facetectomy, foraminotomy and excision of herniated	Not subject to pre-service review. Check EIU policy,		
	intervertebral disc, and repair of annular defect with implantation of bone	which is one of our Clinical Payment and Coding		
	· · · · · · · · · · · · · · · · · · ·	Policy (CPCP).		
	alignment and sizing assessment, and image guidance; 1 interspace,			
00700	lumbar Endoscopic ultrasound-guided direct measurement of hepatic	FILL Durandum / and in a making house of but the Dian	0/4/0004	40/04/0000
C9768	portosystemic pressure gradient by any method (list separately in addition	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy,	3/1/2021	12/31/2999
	to code for primary procedure)	which is one of our Clinical Payment and Coding		
	to code for primary procedure)	Policy (CPCP).		
C9771	Nasal/sinus endoscopy cryoablation nasal tissue(s) and/or nerve(s)	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2023
	unilateral or bilateral	Not subject to pre-service review. Check EIU policy,	5, 10/2021	12/01/2020
	aa.c. ar or bilatoral	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies), with intravascular lithotripsy, includes angioplasty within the	Not subject to pre-service review. Check EIU policy,		
	same vessel (s), when performed	which is one of our Clinical Payment and Coding		
	, , ,	Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy, and transluminal stent	Not subject to pre-service review. Check EIU policy,		
	placement(s), includes angioplasty within the same vessel(s), when	which is one of our Clinical Payment and Coding		
	performed	Policy (CPCP).		
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy and atherectomy, includes	Not subject to pre-service review. Check EIU policy,		
	angioplasty within the same vessel (s), when performed	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	artery(ies); with intravascular lithotripsy and transluminal stent	Not subject to pre-service review. Check EIU policy,		
	placement(s), and atherectomy, includes angioplasty within the same	which is one of our Clinical Payment and Coding		
	vessel (s), when performed	Policy (CPCP).		
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral,	EIU: Procedure/service not reimbursed by the Plan.	8/15/2021	12/31/2999
	includes esophagoscopy or esophagogastroduodenoscopy	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
	esophagogastroduodenoscopy and intraluminal tube insertion, if	Not subject to pre-service review. Check EIU policy,		
	performed, including all system and tissue anchoring components	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
	and intraluminal tube insertion, if performed, including all system and	Not subject to pre-service review. Check EIU policy,		
	tissue anchoring components	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])	Not subject to pre-service review. Check EIU policy,		
	, , , , , , , , , , , , , , , , , , , ,	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0469	Lung expansion airway clearance, continuous high frequency oscillation,	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	and nebulization device	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0490	Power source and control electronics unit for oral device/appliance for	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	neuromuscular electrical stimulation of the tongue muscle, controlled by	Not subject to pre-service review. Check EIU policy,		
	hardware remote	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0491	Oral device/appliance for neuromuscular electrical stimulation of the	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	tongue muscle, used in conjunction with the power source and control	Not subject to pre-service review. Check EIU policy,		
	electronics unit, controlled by hardware remote, 90-day supply	which is one of our Clinical Payment and Coding		
	.,,,,,	Policy (CPCP).		
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation	Non Covered: Procedure/service not covered by the	12/1/2020	12/31/2999
	cycle, for arterial insufficiency (unilateral or bilateral system)	Plan. Not subject to pre-service review.		
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
_ _ .	region	Not subject to pre-service review. Check EIU policy,		
	1-3	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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,	5/15/2024	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist		5/15/2024	12/31/2999
20701	External appearance cannot cannot be the peripheral nervee of the times	Not subject to pre-service review. Check EIU policy,	0/10/2021	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION,	EIU: Procedure/service not reimbursed by the Plan.	4/1/2022	12/31/2999
	TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE	Not subject to pre-service review. Check EIU policy,		
	GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR	which is one of our Clinical Payment and Coding		
	WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER	Policy (CPCP).		
	COMPLETION OF TRAINING PROGRAM			
E0830	Ambulatory traction device, all types, each	Non Covered: Procedure/service not covered by the	12/15/2014	12/31/2999
		Plan. Not subject to pre-service review.		
E0840	Traction frame, attached to headboard, cervical traction	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
	STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO	Plan. Not subject to pre-service review.		
E0850	OTHER THAN MANDIBLE Traction stand, free standing, cervical traction	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
E0000	Traction stand, free standing, dervical traction	The state of the s	9/1/2020	12/31/2999
E0855	Cervical traction equipment not requiring additional stand or frame	Plan. Not subject to pre-service review. Non Covered: Procedure/service not covered by the	12/15/2014	12/31/2999
L0033	Cervical traction equipment not requiring additional stand of frame	Plan. Not subject to pre-service review.	12/13/2014	12/31/2999
E0856	Cervical traction device, with inflatable air bladder(s)	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
20000	Corrida Racion acrisc, with innatable all bladder(c)	Plan. Not subject to pre-service review.	07 172020	12/01/2000
E0860	Traction equipment, overdoor, cervical	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		
E0890	Traction frame, attached to footboard, pelvic traction	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		
E0942	Cervical head harness/halter	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		
E0944	Pelvic belt/harness/boot	Non Covered: Procedure/service not covered by the	9/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		
E1632	Wearable artificial kidney, each	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
=		Policy (CPCP).	5/45/0004	10/01/0000
E3000	Speech volume modulation system, any type, including all components	EIU: Procedure/service not reimbursed by the Plan.	5/15/2024	12/31/2999
	and accessories	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g.,	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
G0420	Collagen Meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/31/2999
	Civil, Collagett Scattolic, Ivietiallex)	which is one of our Clinical Payment and Coding		
		•		
		Policy (CPCP).		

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	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	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	diathermy treatment device, per month	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
K1037	Docking station for use with oral device/appliance used to reduce upper	EIU: Procedure/service not reimbursed by the Plan.	10/1/2024	12/31/2999
	airway collapsibility	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
₋ 5991	Addition to lower extremity prostheses, osseointegrated external	EIU: Procedure/service not reimbursed by the Plan.	10/1/2023	12/31/2999
	prosthetic connector	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
₋ 8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant,	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	anal canal, 1 ml, includes shipping and necessary supplies	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by the Plan.	1. 10/1/2024 9. 10. 10/1/2023 9. 11. 12/1/2020 9. 11. 1/1/2023 9. 11. 6/1/2023 9. 11. 6/1/2023 9. 11. 6/1/2023 9. 11. 6/1/2023 9. 11. 6/1/2023 9. 11. 6/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0240	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	Not subject to pre-service review. Check EIU policy,		
	monitoring, subsequent repeat doses	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0241	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	Not subject to pre-service review. Check EIU policy,		
	monitoring in the home or residence, this includes a beneficiary's home	which is one of our Clinical Payment and Coding		
	that has been made provider-based to the hospital during the covid-19	Policy (CPCP).		
	public health emergency, subsequent repeat doses			
M0243	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	Not subject to pre-service review. Check EIU policy,		
	monitoring	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0244	Intravenous infusion or subcutaneous injection, casirivimab and	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
	imdevimab includes infusion or injection, and post administration	Not subject to pre-service review. Check EIU policy,		
	monitoring in the home or residence; this includes a beneficiary's home	which is one of our Clinical Payment and Coding		
	that has been made provider-based to the hospital during the covid-19	Policy (CPCP).		
	public health emergency			
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3/31/2025
	and post administration monitoring	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
M0246	Intravenous infusion, bamlanivimab and etesevimab, includes infusion	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3/31/2025
	and post administration monitoring in the home or residence; this includes			
	a beneficiary's home that has been made provider based to the hospital	which is one of our Clinical Payment and Coding		
	during the covid 19 public health emergency	Policy (CPCP).		
P9020	Platelet rich plasma, each unit	Non Covered: Procedure/service not covered by the	12/1/2020	12/31/2999
		Plan. Not subject to pre-service review.		

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.	6/1/2023	1/31/2025
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q0243	Injection, casirivimab and imdevimab, 2400 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q0244	Injection, casirivimab and imdevimab, 1200 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	1/31/2025
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	EIU: Procedure/service not reimbursed by the Plan.	6/1/2023	3/31/2025
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	SQUARE CENTIMETER	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4112	CYMETRA, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1CC	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		1-7-11-11-11
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
- · · · -		Not subject to pre-service review. Check EIU policy,		0 ./ _ 000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
K 1 1 1 1	THE STATE OF THE SECOND CONTINUE TEN	Not subject to pre-service review. Check EIU policy,	0, 10,2021	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4152	Dermapure, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4153	Dermavest and plurivest, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4155	Neoxflo or clarixflo, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4156	Neox 100 or clarix 100, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4157	Revitalon, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4158	Kerecis omega3, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	3 /1 1	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4160	Nushield, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4161	Bio-connekt wound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24162	Woundex flow, bioskin flow, 0.5 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4163	Woundex, bioskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	, , , , ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4164	Helicoll, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4165	Keramatrix or kerasorb, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Telement of Roldoors, por oqualo continuotor	Not subject to pre-service review. Check EIU policy,	5, . 5, 202 1	.=,01/2000
		which is one of our Clinical Payment and Coding		
		· · · · · · · · · · · · · · · · · · ·		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4166	Cytal, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4167	Truskin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4169	Artacent wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4170	Cygnus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4171	Interfyl, 1 mg	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4173	Palingen or palingen xplus, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	·gg, p, p	Not subject to pre-service review. Check EIU policy,	1,	,
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
• • • •	·	Not subject to pre-service review. Check EIU policy,	1,	,
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4175	Miroderm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2021	12/31/2999
	initiation, per equal o continuous.	Not subject to pre-service review. Check EIU policy,	., .,	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4176	Neopatch or therion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Troopator of anomon, per oqual o committee	Not subject to pre-service review. Check EIU policy,	, .,_0_0	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4177	Floweramnioflo, 0.1 cc	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
*	Troword milene, 6.1 66	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4178	Floweramniopatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
X-T11 U	i iomoraniniopatori, por oquare centinieter	Not subject to pre-service review. Check EIU policy,	12/1/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
Q4179	Flowerderm, per square centimeter	Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
4119	nowerdenn, per square centimeter	Not subject to pre-service review. Check EIU policy,	3/13/2021	12/31/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

			Ending Date
Revita, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Amnio wound, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Transcyte, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2021	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Surgigraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	Policy (CPCP).		
Cellesta or cellesta duo, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
'' '			
	,		
Cellesta flowable amnion (25 mg per cc); per 0.5 cc		12/1/2020	12/31/2999
(01 //1			
Amnioarmor, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
Artacent ac, 1 mg		12/1/2020	12/31/2999
, •			
Artacent ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
, '			
Restorigin, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
			,
	which is one of our Clinical Payment and Coding		
Restorigin, 1 cc		12/1/2020	12/31/2999
			0 ., _ 0 0 0
Coll-e-derm, per square centimeter		5/15/2021	12/31/2999
con a dorn, por aquara continuotor		0, 10,2021	12/01/2000
	· · · · · · · · · · · · · · · · · · ·		
	Transcyte, per square centimeter Surgigraft, per square centimeter Cellesta or cellesta duo, per square centimeter Cellesta flowable amnion (25 mg per cc); per 0.5 cc Amnioarmor, per square centimeter Artacent ac, 1 mg	which is one of our Clinical Payment and Coding Policy (CPCP). 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). 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). 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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Cellesta or cellesta duo, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). 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). Artacent ac, 1 mg Artacent ac, 1 mg 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). 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). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU:	which is one of our Clinical Payment and Coding Policy (CPCP). Amnio wound, per square centimeter EIL: Procedure/service not reimbursed by the Plan. 12/1/2020 Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Surgigraft, per square centimeter EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Cellesta or cellesta duo, per square centimeter EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Cellesta flowable amnion (25 mg per cc); per 0.5 cc EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Amnioarmor, per square centimeter EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Artacent ac, 1 mg EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Artacent ac, per square centimeter EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Restorigin, per square centimeter EIL: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (C

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4258	Enverse, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	8/1/2022	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4259	Celera dual layer or celera dual membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4260	Signature apatch, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4261	Tag, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4262	Dual layer impax membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
	which is one	which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4263	Surgraft tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4264	Cocoon membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	1/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4265	Neostim tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4266	Neostim membrane, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4267	Neostim dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
14268	Surgraft ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4269	Surgraft xt, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
	, ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4270	Complete sl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4271	Complete ft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	9/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4272	Esano a, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24273	Esano aaa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	an. 12/1/2023 icy, 3 an. 12/1/2023 icy, 3 an. 12/1/2023 icy, 3 an. 12/1/2023 icy, 3 an. 12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4274	Esano ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4275	Esano aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4276	Orion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4277	Woundplus membrane or e-graft per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	6/30/2024
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4278	Epieffect, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4279	Vendaje ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	, ,, ,	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4280	Xcell amnio matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
	, F	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4281	Barrera sl or barrera dl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	12/1/2023	12/31/2999
_ .	25.15.2 5. 51 ballota al, por oquaro obitalliotor	Not subject to pre-service review. Check EIU policy,	, ., _ 0 _ 0	.=,01/2000
		which is one of our Clinical Payment and Coding		
		·		
		Policy (CPCP).		

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

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.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4296	Rebound matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4297	Emerge matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4298	Amnicore pro, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4299	Amnicore pro+, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
14300	Acesso tl, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4301	Activate matrix, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4302	Complete aca, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
04303	Complete aa, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4305	American amnion ac tri-layer, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
24306	American amnion ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
4.000	, F	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4307	American amnion, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,	., .,	.2,01,2000
		which is one of our Clinical Payment and Coding		
		•		
		Policy (CPCP).		

			Ending Date
Sanopellis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	4/1/2024	12/31/2999
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Via matrix, per square centimeter		4/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Procenta, per 100 mg		4/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Acesso, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Acesso ac, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy,		
	Policy (CPCP).		
Dermabind fm, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy.		
	which is one of our Clinical Payment and Coding		
	Policy (CPCP).		
Reeva ft, per square cenitmeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy.		
Regenelink amniotic membrane allograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy.		
Amchoplast, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
	Not subject to pre-service review. Check EIU policy.		
Vitograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
E-graft, per square centimeter		7/1/2024	12/31/2999
	•		
Sanograft, per square centimeter		7/1/2024	12/31/2999
3, F			_, _ , _ , _ ,
	Via matrix, per square centimeter Procenta, per 100 mg Acesso, per square centimeter Acesso ac, per square centimeter Dermabind fm, per square centimeter Reeva ft, per square cenitmeter Regenelink amniotic membrane allograft, per square centimeter	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Via matrix, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Dermabind fm, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Reeva ft, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Amchoplast, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Amchoplast, per square centimeter EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-serv	Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Via matrix, per square centimeter Via matrix, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Procenta, per 100 mg EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Acesso, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Acesso ac, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Reeva ft, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Regenelink amniotic membrane allograft, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). Arnchoplast, per square centimeter EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). EIL! Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clin

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4332	Axolotl dualgraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4333	Ardeograft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	7/1/2024	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4334	Amnioplast 1, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4335	Amnioplast 2, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4336	Artacent c, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4337	Artacent trident, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		,
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4338	Artacent velos, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		,
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4339	Artacent vericlen, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
2.000	,	Not subject to pre-service review. Check EIU policy,	0, 10,2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4340	Simpligraft, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
2.0.0	Jampingsant, por oqualo continuoto:	Not subject to pre-service review. Check EIU policy,	0, 10,2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4341	Simplimax, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
~ . ~	Sprian, por oqualo continuoto	Not subject to pre-service review. Check EIU policy,	0, 10,2020	.2,01,2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4342	Theramend, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
	Thoramona, per square continued	Not subject to pre-service review. Check EIU policy,	0,10/2020	12/01/2000
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter		5/15/2025	12/31/2999
(1010	Dermacyte ac matrix ammotic membrane allograft, per square centimeter	Not subject to pre-service review. Check EIU policy,	3/13/2023	12/3/1/2999
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		

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.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
Q4345	Matrix hd allograft dermis, per square centimeter	EIU: Procedure/service not reimbursed by the Plan.	5/15/2025	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2117	Arthroereisis, subtalar	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3650	Saliva test, hormone level; during menopause	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S3652	Saliva test, hormone level; to assess preterm labor risk	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
		Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9001	Home uterine monitor with or without associated nursing services	EIU: Procedure/service not reimbursed by the Plan.	9/1/2020	12/31/2999
	, and the second	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by the Plan.	12/1/2020	12/31/2999
	'	Not subject to pre-service review. Check EIU policy,		
		which is one of our Clinical Payment and Coding		
		Policy (CPCP).		
S9090	Vertebral axial decompression, per session	Non Covered: Procedure/service not covered by the	12/15/2014	12/31/2999
		Plan. Not subject to pre-service review.		
A0225	Ambulance service, neonatal transport, base rate, emergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	one way	Medical Policy Criteria. Submit for Recommended		
	·,	Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0380	BLS mileage	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0382	Basic Life Support (BLS) routine disposable supplies	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	2000 2.10 Capport (BEO) Toutino dioposablo supplies	Medical Policy Criteria. Submit for Recommended		, 5 1, 2000
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
		LOUE IS MAIAGED BY AIACUIA.		

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(Advanced Life Support) ambulances and BLS ambulances in	Medical Policy Criteria. Submit for Recommended		
	jurisdictions where defibrillation is permitted in BLS ambulances)	Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0390	ALS mileage	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0392	ALS specialized service disposable supplies; defibrillation (to be used	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	only in jurisdictions where defibrillation cannot be performed by BLS	Medical Policy Criteria. Submit for Recommended		
	ambulances)	Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0394	ALS specialized service disposable supplies; IV drug therapy	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0396	ALS specialized service disposable supplies; esophageal intubation	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0398	ALS routine disposable supplies	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour increments	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	situation	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	winged); (requires medical review)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0425	Ground mileage, per statute mile	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
		Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
A0426	Ambulance service, advanced life support, non-emergency transport,	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	Level 1 (ALS1)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		
40427	Ambulance service, advanced life support, emergency transport, Level 1	MP Criteria: Procedure/service reviewed against	1/1/2025	12/31/2999
	(ALS1-Emergency)	Medical Policy Criteria. Submit for Recommended		
		Clinical Review to avoid post-service review. This		
		code is managed by Alacura.		

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
\0433	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
59961	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

CPT copyright 2024 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

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.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Alacura Medical Transportation Management, LLC. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide utilization management services for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.