BlueCross BlueShield of Texas

2026 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List - Non-ERISA
Effective 1/1/2026 through 1/1/2027
(Updated January 2026)

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, 2026**	**Utilization Management Process** **This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.**

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Rotary Wing & Ground Ambulance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Managed by Alacura.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	Medical Policy Coverage statement indicates procedure/service is experimental, investigational, and/or unproven in all situations.

Unlisted or Undefined	Procedures/services not specifically defined or classified, may be subject to contract/clinical review.

Note: Some codes will appear twice if Ending Date and Effective Date are within the same quarter period.

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
797	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	1/1/1950	12/31/2999
11950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg collagen); 1 cc or less	1/1/1950	12/31/2999
11951	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg collagen); 1.1 to 5.0 cc	1/1/1950	12/31/2999
11952	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg collagen); 5.1 to 10.0 cc	1/1/1950	12/31/2999
11954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg collagen); over 10.0 cc	1/1/1950	12/31/2999
11960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of tissue expander(s) for other than breast including subsequent expansion	3/1/2006	12/31/2999
11970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of tissue expander with permanent implant	3/1/2006	12/31/2999
11980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	1/1/1950	12/31/2999
15011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	11/1/2025	12/31/2999

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15012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less; each additional 25 sq cm or part therof (List separately in addition to code for primary procedure)	11/1/2025	12/31/2999
15013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of skin cell suspension autograft requiring enzymatic processing manual mechanical disaggregation of skin cells and filtration; first 25 sq cm or less of harvested skin	11/1/2025	12/31/2999
15014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of skin cell suspension autograft requiring enzymatic processing manual mechanical disaggregation of skin cells and filtration; each additional 25 sq cm of harvested skin or part therof (List separately in addition to code for primary procedure)	11/1/2025	12/31/2999
15015	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin cell suspension autograft to wound and donor sites including application of primary dressing trunk arms legs; first 480 sq cm or less	11/1/2025	12/31/2999
15016	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin cell suspension autograft to wound and donor sites including application of primary dressing trunk arms legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	11/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15017	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin cell suspension autograft to wound and donor sites including application of primary dressing face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits; first 480 sq cm or less	11/1/2025	12/31/2999
15018	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin cell suspension autograft to wound and donor sites including application of primary dressing face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	11/1/2025	12/31/2999
15271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk arms legs total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4/1/2023	12/31/2999
15272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk arms legs total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
15273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk arms legs total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area or 1% of body area of infants and children	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk arms legs total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
15275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4/1/2023	12/31/2999
15276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
15277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area or 1% of body area of infants and children	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
15758	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Free fascial flap with microvascular anastomosis	11/15/2010	12/31/2999
15769	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous soft tissue other harvested by direct excision (eg fat dermis fascia)	1/15/2021	12/31/2999
15771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to trunk breasts scalp arms and/or legs; 50 cc or less injectate	1/15/2021	12/31/2999
15772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to trunk breasts scalp arms and/or legs; each additional 50 cc injectate or part thereof (List separately in addition to code for primary procedure)	1/15/2021	12/31/2999
15775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; 1 to 15 punch grafts	9/24/2012	12/31/2999
15776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; more than 15 punch grafts	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; total face (eg for acne scarring fine wrinkling rhytids general keratosis)	8/1/2005	12/31/2999
15781	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; segmental face	8/1/2005	12/31/2999
15782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; regional other than face	1/1/1950	12/31/2999
15783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; superficial any site (eg tattoo removal)	1/1/1950	12/31/2999
15786	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Abrasion; single lesion (eg keratosis scar)	8/1/2005	12/31/2999
15787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	8/1/2005	12/31/2999
15788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel facial; epidermal	1/1/1950	12/31/2999
15789	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel facial; dermal	1/1/1950	12/31/2999
15792	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel nonfacial; epidermal	1/1/1950	12/31/2999
15793	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel nonfacial; dermal	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty lower eyelid;	9/24/2012	12/31/2999
15821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty lower eyelid; with extensive herniated fat pad	9/24/2012	12/31/2999
15822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty upper eyelid;	1/1/1950	12/31/2999
15823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty upper eyelid; with excessive skin weighting down lid	1/1/1950	12/31/2999
15825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; neck with platysmal tightening (platysmal flap P-flap)	9/24/2012	12/31/2999
15828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; cheek chin and neck	9/24/2012	12/31/2999
15829	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	9/24/2012	12/31/2999
15830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); abdomen infraumbilical panniculectomy	1/1/2007	12/31/2999
15832	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); thigh	9/24/2012	12/31/2999
15833	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); leg	9/24/2012	12/31/2999

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15834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); hip	9/24/2012	12/31/2999
15835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); buttock	9/24/2012	12/31/2999
15836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); arm	9/24/2012	12/31/2999
15837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	9/24/2012	12/31/2999
15838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	9/24/2012	12/31/2999
15839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy); other area	9/24/2012	12/31/2999
15847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision excessive skin and subcutaneous tissue (includes lipectomy) abdomen (eg abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	1/1/2007	12/31/2999
15876	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; head and neck	9/24/2012	12/31/2999
15877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; trunk	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; upper extremity	9/24/2012	12/31/2999
15879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; lower extremity	9/24/2012	12/31/2999
15999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, excision pressure ulcer	4/16/2015	12/31/2999
17106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg laser technique); less than 10 sq cm	1/1/2005	12/31/2999
17107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg laser technique); 10.0 to 50.0 sq cm	1/1/1950	12/31/2999
17108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg laser technique); over 50.0 sq cm	1/1/1950	12/31/2999
17380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrolysis epilation each 30 minutes	9/24/2012	12/31/2999
17999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	1/1/1950	12/31/2999
19105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation cryosurgical of fibroadenoma including ultrasound guidance each fibroadenoma	9/24/2012	12/31/2999
19300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy for gynecomastia	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy simple complete	1/1/2007	12/31/2999
19318	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Breast reduction	6/15/2023	12/31/2999
19325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Breast augmentation with implant	1/1/1950	12/31/2999
19328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intact breast implant	1/1/1950	12/31/2999
19330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ruptured breast implant including implant contents (eg saline silicone gel)	1/1/1950	12/31/2999
19340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of breast implant on same day of mastectomy (ie immediate)	1/1/1950	12/31/2999
19342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of breast implant on separate day from mastectomy	7/1/2005	12/31/2999
19350	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nipple/areola reconstruction	6/1/2017	12/31/2999
19355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Correction of inverted nipples	1/1/1950	12/31/2999
19357	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tissue expander placement in breast reconstruction including subsequent expansion(s)	6/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of peri-implant capsule breast including capsulotomy capsulorrhaphy and/or partial capsulectomy	1/1/1950	12/31/2999
19371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peri-implant capsulectomy breast complete including removal of all intracapsular contents	1/1/1950	12/31/2999
19499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, breast	1/1/1950	12/31/2999
19499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure breast	11/1/2017	12/31/2999
20979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low intensity ultrasound stimulation to aid bone healing noninvasive (nonoperative)	1/1/2026	12/31/2999
20982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg metastasis) including adjacent soft tissue when involved by tumor extension percutaneous including imaging guidance when performed; radiofrequency	8/15/2007	12/31/2999
20983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg metastasis) including adjacent soft tissue when involved by tumor extension percutaneous including imaging guidance when performed; cryoablation	1/1/2020	12/31/2999
20985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted surgical navigational procedure for musculoskeletal procedures image-less (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
20999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, musculoskeletal system, general	4/16/2015	12/31/2999
21032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Excision of maxillary torus palatinus	1/1/1950	12/31/2999
21083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation; palatal lift prosthesis	10/1/2006	12/31/2999
21089	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted maxillofacial prosthetic procedure	1/1/1950	12/31/2999
21120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; augmentation (autograft allograft prosthetic material)	9/24/2012	12/31/2999
21121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomy single piece	9/24/2012	12/31/2999
21122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomies 2 or more osteotomies (eg wedge excision or bone wedge reversal for asymmetrical chin)	9/24/2012	12/31/2999
21123	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding augmentation with interpositional bone grafts (includes obtaining autografts)	9/24/2012	12/31/2999
21244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible extraoral with transosteal bone plate (eg mandibular staple bone plate)	1/1/1950	12/31/2999
21245	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla subperiosteal implant; partial	1/1/1950	12/31/2999

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21246	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla subperiosteal implant; complete	1/1/1950	12/31/2999
21248	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	1/1/1950	12/31/2999
21249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	1/1/1950	12/31/2999
21299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted craniofacial and maxillofacial procedure	1/1/1950	12/31/2999
21499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, head	4/16/2015	12/31/2999
21685	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hyoid myotomy and suspension	3/15/2024	12/31/2999
21899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, neck or thorax	4/16/2015	12/31/2999
22899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, spine	4/16/2015	12/31/2999
22999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, musculoskeletal system	4/16/2015	12/31/2999
23929	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, shoulder	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
23929	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure shoulder	11/1/2017	12/31/2999
24999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, humerus or elbow	4/16/2015	12/31/2999
25999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, forearm or wrist	4/16/2015	12/31/2999
26989	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hands or fingers	4/16/2015	12/31/2999
27299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pelvis or hip joint	4/16/2015	12/31/2999
27299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure pelvis or hip joint	6/1/2017	12/31/2999
27599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, femur or knee	4/16/2015	12/31/2999
27702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty ankle; with implant (total ankle)	12/15/2009	12/31/2999
27703	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty ankle; revision total ankle	5/1/2015	12/31/2999
27899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, leg or ankle	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
28899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, foot or toes	4/16/2015	12/31/2999
29799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, casting or strapping	1/1/1950	12/31/2999
29999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, arthroscopy	1/1/1950	12/31/2999
29999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure arthroscopy	11/1/2017	12/31/2999
30999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nose	1/1/1950	12/31/2999
31299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, accessory sinuses	1/1/1950	12/31/2999
31599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, larynx	1/1/1950	12/31/2999
31647	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bronchoscopy rigid or flexible including fluoroscopic guidance when performed; with balloon occlusion when performed assessment of air leak airway sizing and insertion of bronchial valve(s) initial lobe	11/1/2019	12/31/2999
31648	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bronchoscopy rigid or flexible including fluoroscopic guidance when performed; with removal of bronchial valve(s) initial lobe	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31649	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bronchoscopy rigid or flexible including fluoroscopic guidance when performed; with removal of bronchial valve(s) each additional lobe (List separately in addition to code for primary procedure)	11/1/2019	12/31/2999
31651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bronchoscopy rigid or flexible including fluoroscopic guidance when performed; with balloon occlusion when performed assessment of air leak airway sizing and insertion of bronchial valve(s) each additional lobe (List separately in addition to code for primary procedure[s])	11/1/2019	12/31/2999
31899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, trachea, bronchi	1/1/1950	12/31/2999
32994	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension percutaneous including imaging guidance when performed unilateral; cryoablation	1/1/2018	12/31/2999
32998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension percutaneous including imaging guidance when performed unilateral; radiofrequency	6/1/2007	12/31/2999
32999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lungs and pleura	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	1/1/1950	12/31/2999
33213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacemaker pulse generator only; with existing dual leads	1/1/1950	12/31/2999
33225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacing electrode cardiac venous system for left ventricular pacing at time of insertion of implantable defibrillator or pacemaker pulse generator (eg for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	4/15/2006	12/31/2999
33285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion subcutaneous cardiac rhythm monitor including programming	1/1/2019	12/31/2999
33289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring including deployment and calibration of the sensor right heart catheterization selective pulmonary catheterization radiological supervision and interpretation and pulmonary artery angiography when performed	1/1/2019	12/31/2999
33361	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	1/1/2013	12/31/2999
33362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33363	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	11/1/2015	12/31/2999
33364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	11/1/2015	12/31/2999
33365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg median sternotomy mediastinotomy)	11/1/2015	12/31/2999
33366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg left thoracotomy)	1/1/2014	12/31/2999
33367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg femoral vessels) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
33368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg femoral iliac axillary vessels) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33369	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg aorta right atrium pulmonary artery) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
33418	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis	2/15/2016	12/31/2999
33477	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter pulmonary valve implantation percutaneous approach including pre-stenting of the valve delivery site when performed	1/1/2016	12/31/2999
33927	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	1/1/2018	12/31/2999
33928	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of total replacement heart system (artificial heart)	1/1/2018	12/31/2999
33999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, cardiac surgery	1/1/1950	12/31/2999
33999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure cardiac surgery	11/1/2017	12/31/2999
36299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular injection	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36465	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg great saphenous vein accessory saphenous vein)	1/1/2018	12/31/2999
36466	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg great saphenous vein accessory saphenous vein) same leg	1/1/2018	12/31/2999
36468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s) of sclerosant for spider veins (telangiectasia) limb or trunk	9/24/2012	12/31/2999
36470	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; single incompetent vein (other than telangiectasia)	1/1/1950	12/31/2999
36471	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; multiple incompetent veins (other than telangiectasia) same leg	1/1/1950	12/31/2999
36475	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein extremity inclusive of all imaging guidance and monitoring percutaneous radiofrequency; first vein treated	8/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36476	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein extremity inclusive of all imaging guidance and monitoring percutaneous radiofrequency; subsequent vein(s) treated in a single extremity each through separate access sites (List separately in addition to code for primary procedure)	8/1/2006	12/31/2999
36478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein extremity inclusive of all imaging guidance and monitoring percutaneous laser; first vein treated	8/1/2006	12/31/2999
36479	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein extremity inclusive of all imaging guidance and monitoring percutaneous laser; subsequent vein(s) treated in a single extremity each through separate access sites (List separately in addition to code for primary procedure)	8/1/2006	12/31/2999
36482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein extremity by transcatheter delivery of a chemical adhesive (eg cyanoacrylate) remote from the access site inclusive of all imaging guidance and monitoring percutaneous; first vein treated	9/1/2019	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s) intrathoracic common carotid artery or innominate artery open or percutaneous antegrade approach including angioplasty when performed and radiological supervision and interpretation	1/1/2015	12/31/2999
37241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion inclusive of all radiological supervision and interpretation intraprocedural roadmapping and imaging guidance necessary to complete the intervention; venous other than hemorrhage (eg congenital or acquired venous malformations venous and capillary hemangiomas varices varicoceles)	1/1/2014	12/31/2999
37242	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion inclusive of all radiological supervision and interpretation intraprocedural roadmapping and imaging guidance necessary to complete the intervention; arterial other than hemorrhage or tumor (eg congenital or acquired arterial malformations arteriovenous malformations arteriovenous fistulas aneurysms pseudoaneurysms)	1/1/2014	12/31/2999
37243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion inclusive of all radiological supervision and interpretation intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for tumors organ ischemia or infarction	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion inclusive of all radiological supervision and interpretation intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	1/1/2014	12/31/2999
37254	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37255	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37256	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37258	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37259	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous iliac vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37262	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravascular lithotripsy(ies) iliac vascular territory including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37269	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral and popliteal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37279	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravascular lithotripsy(ies) femoral and popliteal vascular territory including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37281	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure) lesion initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37288	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion initial vessel	1/1/2026	12/31/2999
37293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; straightforward lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous tibial and peroneal vascular territory with transluminal stent placement with transluminal atherectomy including transluminal angioplasty when performed including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement atherectomy and angioplasty when performed within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous inframalleolar vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; complex lesion initial vessel	1/1/2026	12/31/2999
37299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous inframalleolar vascular territory with transluminal angioplasty including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery unilateral; complex lesion each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular endoscopy surgical with ligation of perforator veins subfascial (SEPS)	8/1/2006	12/31/2999
37501	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vascular endoscopy procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of long saphenous vein at saphenofemoral junction or distal interruptions	8/1/2006	12/31/2999
37718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation division and stripping short saphenous vein	8/1/2006	12/31/2999
37722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation division and stripping long (greater) saphenous veins from saphenofemoral junction to knee or below	8/1/2006	12/31/2999
37735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	8/1/2006	12/31/2999
37760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator veins subfascial radical (Linton type) including skin graft when performed open 1 leg	8/1/2006	12/31/2999
37761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator vein(s) subfascial open including ultrasound guidance when performed 1 leg	1/1/2010	12/31/2999
37765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins 1 extremity; 10-20 stab incisions	8/1/2006	12/31/2999
37766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins 1 extremity; more than 20 incisions	8/1/2006	12/31/2999
37780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	8/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation division and/or excision of varicose vein cluster(s) 1 leg	8/1/2006	12/31/2999
37799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular surgery	1/1/1950	12/31/2999
38129	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spleen	1/1/1950	12/31/2999
38204	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	1/1/1950	12/31/2999
38205	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blood-derived hematopoietic progenitor cell harvesting for transplantation per collection; allogeneic	1/1/1950	12/31/2999
38207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	1/1/1950	12/31/2999
38208	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest without washing per donor	1/1/1950	12/31/2999
38209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest with washing per donor	1/1/1950	12/31/2999
38210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest T-cell depletion	1/1/1950	12/31/2999
38211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38212	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	1/1/1950	12/31/2999
38213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; platelet depletion	1/1/1950	12/31/2999
38214	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	1/1/1950	12/31/2999
38215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma mononuclear or buffy coat layer	1/1/1950	12/31/2999
38232	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bone marrow harvesting for transplantation; autologous	1/1/2012	12/31/2999
38240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	1/1/1950	12/31/2999
38308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lymphangiotomy or other operations on lymphatic channels	12/1/2014	12/31/2999
38589	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, lymphatic system	1/1/1950	12/31/2999
38999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hemic or lymphatic system	1/1/1950	12/31/2999
39499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, mediastinum	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
39599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, diaphragm	1/1/1950	12/31/2999
40799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lips	1/1/1950	12/31/2999
40899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vestibule of mouth	1/1/1950	12/31/2999
41120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Glossectomy; less than one-half tongue	3/15/2024	12/31/2999
41512	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tongue base suspension permanent suture technique	1/1/2009	12/31/2999
41530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal ablation of the tongue base radiofrequency 1 or more sites per session	4/1/2024	12/31/2999
41599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, tongue, floor of mouth	1/1/1950	12/31/2999
41872	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gingivoplasty each quadrant (specify)	2/1/2024	12/31/2999
41899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, dentoalveolar structures	1/1/1950	12/31/2999
42140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Uvulectomy excision of uvula	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
42145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Palatopharyngoplasty (eg uvulopalatopharyngoplasty uvulopharyngoplasty)	1/1/1950	12/31/2999
42299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, palate, uvula	1/1/1950	12/31/2999
42699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, salivary glands or ducts	1/1/1950	12/31/2999
42950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharyngoplasty (plastic or reconstructive operation on pharynx)	3/15/2024	12/31/2999
42999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pharynx, adenoids, or tonsils	1/1/1950	12/31/2999
43236	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy flexible transoral; with directed submucosal injection(s) any substance	1/1/1950	12/31/2025
43257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy flexible transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia for treatment of gastroesophageal reflux disease	5/1/2010	12/31/2999
43281	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical repair of paraesophageal hernia includes fundoplasty when performed; without implantation of mesh	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical esophageal sphincter augmentation procedure placement of sphincter augmentation device (ie magnetic band) including cruroplasty when performed	1/1/2017	12/31/2999
43289	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, esophagus	1/1/1950	12/31/2999
43289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted laparoscopy procedure esophagus	6/1/2017	12/31/2999
43332	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via laparotomy except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43333	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via laparotomy except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43334	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via thoracotomy except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43335	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via thoracotomy except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43336	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via thoracoabdominal incision except neonatal; without implantation of mesh or other prosthesis	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43337	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair paraesophageal hiatal hernia (including fundoplication) via thoracoabdominal incision except neonatal; with implantation of mesh or other prosthesis	1/1/2026	12/31/2999
43499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, esophagus	1/1/1950	12/31/2999
43632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy partial distal; with gastrojejunostomy	6/1/2023	12/31/2999
43633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy partial distal; with Roux-en-Y reconstruction	7/1/2007	12/31/2999
43634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy partial distal; with formation of intestinal pouch	1/1/2026	12/31/2999
43644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	1/1/2005	12/31/2999
43645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	11/1/2019	12/31/2999
43659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, stomach	1/1/1950	12/31/2999
43770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; placement of adjustable gastric restrictive device (eg gastric band and subcutaneous port components)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; revision of adjustable gastric restrictive device component only	1/1/2006	12/31/2999
43772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; removal of adjustable gastric restrictive device component only	1/1/2006	12/31/2999
43773	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	1/1/2006	12/31/2999
43774	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	1/1/2006	12/31/2999
43775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical gastric restrictive procedure; longitudinal gastrectomy (ie sleeve gastrectomy)	7/1/2010	12/31/2999
43820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrojejunostomy; without vagotomy	1/1/2026	12/31/2999
43842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure without gastric bypass for morbid obesity; vertical-banded gastroplasty	9/1/2020	12/31/2999
43843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure without gastric bypass for morbid obesity; other than vertical-banded gastroplasty	1/1/1950	12/31/2999
43845	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure with partial gastrectomy pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	9/15/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	1/1/1950	12/31/2999
43847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	11/1/2019	12/31/2999
43848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision open of gastric restrictive procedure for morbid obesity other than adjustable gastric restrictive device (separate procedure)	1/1/1950	12/31/2999
43860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction with or without partial gastrectomy or intestine resection; without vagotomy	1/1/2026	12/31/2999
43886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure open; revision of subcutaneous port component only	1/1/2006	12/31/2999
43887	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure open; removal of subcutaneous port component only	1/1/2006	12/31/2999
43888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure open; removal and replacement of subcutaneous port component only	1/1/2006	12/31/2999
43999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, stomach	1/1/1950	12/31/2999
44238	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, intestine (except rectum)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
44799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, small intestine	1/1/1950	12/31/2999
44899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, Meckel's diverticulum and the mesentery	1/1/1950	12/31/2999
44979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, appendix	1/1/1950	12/31/2999
45399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, colon	1/1/2015	12/31/2999
45499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, rectum	1/1/2006	12/31/2999
45999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, rectum	1/1/1950	12/31/2999
46999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anus	1/1/1950	12/31/2999
47370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical ablation of 1 or more liver tumor(s); radiofrequency	1/1/1950	12/31/2999
47379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopic procedure, liver	1/1/1950	12/31/2999
47382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation 1 or more liver tumor(s) percutaneous radiofrequency	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47383	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation 1 or more liver tumor(s) percutaneous cryoablation	11/1/2019	12/31/2999
47399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, liver	1/1/1950	12/31/2999
47579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, biliary tract	1/1/1950	12/31/2999
47999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, biliary tract	1/1/1950	12/31/2999
48999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pancreas	1/1/1950	12/31/2999
49329	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
49659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	1/1/1950	12/31/2999
49999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
50250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation open 1 or more renal mass lesion(s) cryosurgical including intraoperative ultrasound guidance and monitoring if performed	6/1/2008	12/31/2999
50360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renal allotransplantation implantation of graft; without recipient nephrectomy	5/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
50541	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical; ablation of renal cysts	3/1/2005	12/31/2999
50542	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy surgical; ablation of renal mass lesion(s) including intraoperative ultrasound guidance and monitoring when performed	1/1/1950	12/31/2999
50549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, renal	1/1/1950	12/31/2999
50592	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation 1 or more renal tumor(s) percutaneous unilateral radiofrequency	1/1/2006	12/31/2999
50593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation renal tumor(s) unilateral percutaneous cryotherapy	6/1/2008	12/31/2999
50949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, ureter	1/1/1950	12/31/2999
51715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	5/1/2007	12/31/2999
51999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, bladder	1/1/2006	12/31/2999
52327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	6/1/2017	12/31/2999
52441	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with insertion of permanent adjustable transprostatic implant; single implant	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
52442	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	12/1/2015	12/31/2999
53899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, urinary system	1/1/1950	12/31/2999
54125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputation of penis; complete	5/1/2006	12/31/2999
54400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; non-inflatable (semi-rigid)	1/1/1950	12/31/2999
54401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; inflatable (self-contained)	1/1/1950	12/31/2999
54405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of multi-component inflatable penile prosthesis including placement of pump cylinders and reservoir	1/1/1950	12/31/2999
54406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of all components of a multi-component inflatable penile prosthesis without replacement of prosthesis	1/1/1950	12/31/2999
54408	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of component(s) of a multi-component inflatable penile prosthesis	1/1/1950	12/31/2999
54410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of all component(s) of a multi-component inflatable penile prosthesis at the same operative session	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session including irrigation and debridement of infected tissue	1/1/1950	12/31/2999
54415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis without replacement of prosthesis	1/1/1950	12/31/2999
54416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	1/1/1950	12/31/2999
54417	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session including irrigation and debridement of infected tissue	1/1/1950	12/31/2999
54660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of testicular prosthesis (separate procedure)	5/1/2006	12/31/2999
54699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, testis	1/1/1950	12/31/2999
55559	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spermatic cord	1/1/1950	12/31/2999
55706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsies prostate needle transperineal stereotactic template guided saturation sampling including imaging guidance	11/15/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
55873	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	6/15/2007	12/31/2999
55880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of malignant prostate tissue transrectal with high intensity-focused ultrasound (HIFU) including ultrasound guidance	2/1/2021	12/31/2999
55899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, male genital system	1/1/1950	12/31/2999
55899	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure male genital system	11/1/2017	12/31/2999
55970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; male to female	5/1/2006	12/31/2999
55980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; female to male	5/1/2006	12/31/2999
56805	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Clitoroplasty for intersex state	5/1/2006	12/31/2999
56810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Perineoplasty repair of perineum nonobstetrical (separate procedure)	6/1/2008	12/31/2999
57291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; without graft	5/1/2006	12/31/2999
57292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; with graft	5/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
57296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	1/1/2007	12/31/2999
57335	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vaginoplasty for intersex state	5/1/2006	12/31/2999
57426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft laparoscopic approach	1/1/2010	12/31/2999
58321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Artificial insemination; intra-cervical	1/1/1950	12/31/2999
58322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Artificial insemination; intra-uterine	1/1/1950	12/31/2999
58323	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm washing for artificial insemination	1/1/1950	12/31/2999
58578	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, uterus	1/1/1950	12/31/2999
58579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hysteroscopy procedure, uterus	1/1/1950	12/31/2999
58580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcervical ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring radiofrequency	2/15/2024	12/31/2999
58679	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, oviduct, ovary	1/1/1950	12/31/2999
58750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tubotubal anastomosis	1/15/2008	12/31/2999
58999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, female genital system (nonobstetrical)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
59072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal umbilical cord occlusion including ultrasound guidance	10/1/2023	12/31/2999
59074	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal fluid drainage (eg vesicocentesis thoracocentesis paracentesis) including ultrasound guidance	12/1/2022	12/31/2999
59076	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal shunt placement including ultrasound guidance	10/1/2023	12/31/2999
59897	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	1/1/1950	12/31/2999
59898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, maternity care and delivery	1/1/1950	12/31/2999
59899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, maternity care and delivery	1/1/1950	12/31/2999
60659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, endocrine system	1/1/1950	12/31/2999
60699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, endocrine system	1/1/1950	12/31/2999
60699	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure endocrine system	10/1/2022	12/31/2999
61635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s) intracranial (eg atherosclerotic stenosis) including balloon angioplasty if performed	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis intracranial any method including diagnostic angiography fluoroscopic guidance catheter placement and intraprocedural pharmacological thrombolytic injection(s)	1/1/2016	12/31/2999
61715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS) stereotactic ablation of target intracranial including stereotactic navigation and frame placement when performed	1/1/2026	12/31/2999
61889	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver including craniectomy or craniotomy when performed with direct or inductive coupling with connection to depth and/or cortical strip electrode array(s)	2/15/2024	12/31/2999
61891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	2/15/2024	12/31/2999
61892	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty when performed	2/15/2024	12/31/2999
62268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous aspiration spinal cord cyst or syrinx	2/1/2025	12/31/2999
63266	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm extradural; thoracic	2/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
63268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm extradural; sacral	2/1/2025	12/31/2999
63271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm intradural; thoracic	2/1/2025	12/31/2999
63273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm intradural; sacral	2/1/2025	12/31/2999
63276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural thoracic	2/1/2025	12/31/2999
63278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural sacral	2/1/2025	12/31/2999
63295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteoplastic reconstruction of dorsal spinal elements following primary intraspinal procedure (List separately in addition to code for primary procedure)	2/1/2025	12/31/2999
64566	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Posterior tibial neurostimulation percutaneous needle electrode single treatment includes programming	3/15/2024	12/31/2999
64568	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of cranial nerve (eg vagus nerve) neurostimulator electrode array and pulse generator	1/1/2022	12/31/2999
64575	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64590	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of peripheral sacral or gastric neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver	1/1/2022	12/31/2999
64596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array peripheral nerve with integrated neurostimulator including imaging guidance when performed; initial electrode array	2/15/2024	12/31/2999
64597	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array peripheral nerve with integrated neurostimulator including imaging guidance when performed; each additional electrode array (List separately in addition to code for primary procedure)	2/15/2024	12/31/2999
64620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent intercostal nerve	2/15/2025	12/31/2999
64624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent genicular nerve branches including imaging guidance when performed	12/1/2023	12/31/2999
64628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thermal destruction of intraosseous basivertebral nerve including all imaging guidance; first 2 vertebral bodies lumbar or sacral	12/1/2025	12/31/2999
64629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thermal destruction of intraosseous basivertebral nerve including all imaging guidance; each additional vertebral body lumbar or sacral (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent; other peripheral nerve or branch	5/15/2021	12/31/2999
64999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nervous system	1/1/1950	12/31/2999
65760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Keratomileusis	1/1/2021	12/31/2999
65767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epikeratoplasty	1/1/1950	12/31/2999
65770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoprosthesis	9/24/2012	12/31/2999
65772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Corneal relaxing incision for correction of surgically induced astigmatism	1/1/2015	12/31/2999
65775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Corneal wedge resection for correction of surgically induced astigmatism	1/1/2015	12/31/2999
66174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg canaloplasty); without retention of device or stent	8/15/2012	12/31/2999
66175	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg canaloplasty); with retention of device or stent	8/15/2012	12/31/2999
66179	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir external approach; without graft	1/1/2015	12/31/2999
66180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir external approach; with graft	5/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
66183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device without extraocular reservoir external approach	1/1/2014	12/31/2999
66989	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure) manual or mechanical technique (eg irrigation and aspiration or phacoemulsification) complex requiring devices or techniques not generally used in routine cataract surgery (eg iris expansion device suture support for intraocular lens or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg trabecular meshwork supraciliary suprachoroidal) anterior segment aqueous drainage device without extraocular reservoir internal approach one or more	3/15/2022	12/31/2999
66991	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure) manual or mechanical technique (eg irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg trabecular meshwork supraciliary suprachoroidal) anterior segment aqueous drainage device without extraocular reservoir internal approach one or more	3/15/2022	12/31/2999
66999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anterior segment of eye	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, posterior segment	1/1/1950	12/31/2999
67399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, extraocular muscle	1/1/1950	12/31/2999
67516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suprachoroidal space injection of pharmacologic agent (separate procedure)	2/15/2024	12/31/2999
67599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, orbit	1/1/1950	12/31/2999
67901	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg banked fascia)	1/1/2005	12/31/2999
67902	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	1/1/2005	12/31/2999
67903	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement internal approach	1/1/2005	12/31/2999
67904	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement external approach	1/1/1950	12/31/2999
67906	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	1/1/1950	12/31/2999
67908	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg Fasanella-Servat type)	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, eyelids	1/1/1950	12/31/2999
68399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, conjunctiva	1/1/1950	12/31/2999
68899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lacrimal system	1/1/1950	12/31/2999
69090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ear piercing	1/1/2020	12/31/2999
69300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Otoplasty protruding ear with or without size reduction	1/1/1950	12/31/2999
69399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, external ear	1/1/1950	12/31/2999
69705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy surgical with dilation of eustachian tube (ie balloon dilation); unilateral	1/15/2021	12/31/2999
69706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy surgical with dilation of eustachian tube (ie balloon dilation); bilateral	1/15/2021	12/31/2999
69728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal entire osseointegrated implant skull; with magnetic transcutaneous attachment to external speech processor outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, middle ear	1/1/1950	12/31/2999
69949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, inner ear	1/1/1950	12/31/2999
69979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, temporal bone, middle fossa approach	1/1/1950	12/31/2999
76120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cineradiography/videoradiography except where specifically included	10/1/2006	12/31/2999
76125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	10/1/2006	12/31/2999
76496	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
76497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted computed tomography procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
76498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
76499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic radiographic procedure	4/16/2015	12/31/2999
76940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultrasound guidance for and monitoring of parenchymal tissue ablation	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
76999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ultrasound procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
77299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology clinical treatment planning	1/1/1950	12/31/2999
77399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	4/16/2015	12/31/2999
77499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology treatment management	1/1/1950	12/31/2999
77799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, clinical brachytherapy	1/1/1950	12/31/2999
78099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted endocrine procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999
78399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted respiratory procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted nervous system procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted genitourinary procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
78999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999
79999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiopharmaceutical therapy, unlisted procedure	1/1/1950	12/31/2999
80299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Quantitation of therapeutic drug, not elsewhere specified	1/1/1950	12/31/2999
81099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted urinalysis procedure	1/1/1950	12/31/2999
81479	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted molecular pathology procedure	1/1/2013	12/31/2999
81599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted multianalyte assay with algorithmic analysis	1/1/2013	12/31/2999
84999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemistry procedure	6/20/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
85999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematology and coagulation procedure	1/1/1950	12/31/2999
86353	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lymphocyte transformation mitogen (phytomitogen) or antigen induced blastogenesis	1/1/1950	12/31/2999
86486	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Skin test; unlisted antigen, each	4/16/2015	12/31/2999
86849	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immunology procedure	1/1/1950	12/31/2999
86910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood typing, for paternity testing, per individual; ABO, Rh and MN	1/1/1950	12/31/2999
86911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood typing, for paternity testing, per individual; each additional antigen system	1/1/1950	12/31/2999
86999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted transfusion medicine procedure	4/16/2015	12/31/2999
87797	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	10/24/2019	12/31/2999
87798	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism	10/24/2019	12/31/2999
87799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism	10/24/2019	12/31/2999
87899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
87999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted microbiology procedure	4/16/2015	12/31/2999
88000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; without CNS	1/1/1950	12/31/2999
88005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; with brain	1/1/1950	12/31/2999
88007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; with brain and spinal cord	1/1/1950	12/31/2999
88012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; infant with brain	1/1/1950	12/31/2999
88014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	1/1/1950	12/31/2999
88016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; macerated stillborn	1/1/1950	12/31/2999
88020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; without CNS	1/1/1950	12/31/2999
88025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; with brain	1/1/1950	12/31/2999
88027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	1/1/1950	12/31/2999
88028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; infant with brain	1/1/1950	12/31/2999
88029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	1/1/1950	12/31/2999
88036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), limited, gross and/or microscopic; regional	1/1/1950	12/31/2999
88037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), limited, gross and/or microscopic; single organ	1/1/1950	12/31/2999
88040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy); forensic examination	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88045	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy); coroner's call	1/1/1950	12/31/2999
88099	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unlisted necropsy (autopsy) procedure	1/1/1950	12/31/2999
88099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted necropsy (autopsy) procedure	4/16/2015	12/31/2999
88199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytopathology procedure	4/16/2015	12/31/2999
88299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytogenetic study	10/24/2014	12/31/2999
88399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted surgical pathology procedure	4/16/2015	12/31/2999
88749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted in vivo (eg, transcutaneous) laboratory service	1/1/2011	12/31/2999
89240	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous pathology test	1/1/1950	12/31/2999
89258	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; embryo(s)	1/1/2007	12/31/2999
89259	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; sperm	1/1/2007	12/31/2999
89335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, reproductive tissue, testicular	3/20/2018	12/31/2999
89337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, mature oocyte(s)	1/1/2019	12/31/2999
89342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); embryo(s)	3/20/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
89343	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); sperm/semen	3/20/2018	12/31/2999
89344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); reproductive tissue, testicular/ovarian	1/1/1950	12/31/2999
89346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); oocyte(s)	3/20/2018	12/31/2999
89352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; embryo(s)	3/20/2018	12/31/2999
89353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; sperm/semen, each aliquot	3/20/2018	12/31/2999
89354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	1/1/1950	12/31/2999
89356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; oocytes, each aliquot	1/1/1950	12/31/2999
89398	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted reproductive medicine laboratory procedure	1/1/2010	12/31/2999
90399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immune globulin	1/1/1950	12/31/2999
90589	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chikungunya virus vaccine, live attenuated, for intramuscular use	8/22/2025	12/31/2999
90666	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use	7/1/2010	12/31/2999
90667	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	7/1/2010	12/31/2999
90668	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use	7/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vaccine/toxoid	1/1/1950	12/31/2999
90867	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial including cortical mapping motor threshold determination delivery and management	9/24/2012	12/31/2999
90868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management per session	9/24/2012	12/31/2999
90869	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	9/24/2012	12/31/2999
90885	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	1/1/1950	12/31/2999
90889	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	1/1/1950	12/31/2999
90899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted psychiatric service or procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted dialysis procedure, inpatient or outpatient	1/1/1950	12/31/2999
91299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic gastroenterology procedure	1/1/1950	12/31/2999
92065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthoptic training; performed by a physician or other qualified health care professional	11/1/2013	12/31/2999
92499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ophthalmological service or procedure	1/1/1950	12/31/2999
92622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis programming and verification of an auditory osseointegrated sound processor any type; first 60 minutes	3/15/2024	12/31/2999
92623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis programming and verification of an auditory osseointegrated sound processor any type; each additional 15 minutes (List separately in addition to code for primary procedure)	3/15/2024	12/31/2999
92700	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted otorhinolaryngological service or procedure	1/1/1950	12/31/2999
92972	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External mobile cardiovascular telemetry with electrocardiographic recording concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	9/1/2020	12/31/2999
93229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External mobile cardiovascular telemetry with electrocardiographic recording concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use attended surveillance analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	1/1/2020	12/31/2999
93580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter closure of congenital interatrial communication (ie Fontan fenestration atrial septal defect) with implant	4/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Evaluation of cardiovascular function with tilt table evaluation with continuous ECG monitoring and intermittent blood pressure monitoring with or without pharmacological intervention	1/1/1950	12/31/2999
93702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bioimpedance spectroscopy (BIS) extracellular fluid analysis for lymphedema assessment(s)	10/15/2025	12/31/2999
93799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular service or procedure	1/1/1950	12/31/2999
93998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted noninvasive vascular diagnostic study	1/1/2012	12/31/2999
94452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	1/1/2005	12/31/2999
94453	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	1/1/2005	12/31/2999
94799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted pulmonary service or procedure	1/1/1950	12/31/2999
95199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted allergy/clinical immunologic service or procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface or of depth electrodes to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	3/1/2024	12/31/2999
95962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface or of depth electrodes to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	3/1/2024	12/31/2999
95965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG) recording and analysis; for spontaneous brain magnetic activity (eg epileptic cerebral cortex localization)	4/1/2009	12/31/2999
95966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG) recording and analysis; for evoked magnetic fields single modality (eg sensory motor language or visual cortex localization)	4/1/2009	12/31/2999
95967	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG) recording and analysis; for evoked magnetic fields each additional modality (eg sensory motor language or visual cortex localization) (List separately in addition to code for primary procedure)	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator system (eg rate pulse amplitude and duration configuration of wave form battery status electrode selectability output modulation cycling impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent without reprogramming	1/1/2008	12/31/2999
95982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator system (eg rate pulse amplitude and duration configuration of wave form battery status electrode selectability output modulation cycling impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent with reprogramming	1/1/2008	12/31/2999
95999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted neurological or neuromuscular diagnostic procedure	1/1/1950	12/31/2999
96000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	7/15/2010	12/31/2999
96001	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	7/15/2010	12/31/2999
96002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dynamic surface electromyography during walking or other functional activities 1-12 muscles	7/15/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis dynamic plantar pressure measurements dynamic surface electromyography during walking or other functional activities and dynamic fine wire electromyography with written report	7/15/2010	12/31/2999
96379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	1/1/2009	12/31/2999
96547	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure including separate incision(s) and closure when performed; first 60 minutes (List separately in addition to code for primary procedure)	3/15/2024	12/31/2999
96548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure including separate incision(s) and closure when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	3/15/2024	12/31/2999
96549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemotherapy procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96571	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	1/1/1950	12/31/2999
96912	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photochemotherapy; psoralens and ultraviolet A (PUVA)	8/15/2009	12/31/2999
96913	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	7/1/2010	12/31/2999
96999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special dermatological service or procedure	1/1/1950	12/31/2999
97037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of a modality to 1 or more areas; low-level laser therapy (ie nonthermal and non-ablative) for post-operative pain reduction	2/15/2024	12/31/2999
97039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted modality (specify type and time if constant attendance)	1/1/1950	12/31/2999
97139	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic procedure (specify)	1/1/1950	12/31/2999
97545	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Work hardening/conditioning; initial 2 hours	5/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97546	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	5/1/2024	12/31/2999
97799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted physical medicine/rehabilitation service or procedure	1/1/1950	12/31/2999
97810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1/1/2005	12/31/2999
97811	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	1/1/2005	12/31/2999
97813	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	1/1/2005	12/31/2999
97814	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	1/1/2005	12/31/2999
99026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospital mandated on call service; in-hospital, each hour	1/1/1950	12/31/2999
99027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospital mandated on call service; out-of-hospital, each hour	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	1/1/1950	12/31/2999
99056	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	1/1/1950	12/31/2999
99058	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	1/1/1950	12/31/2999
99070	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	1/1/1950	12/31/2999
99071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	1/1/1950	12/31/2999
99075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical testimony	1/1/1950	12/31/2999
99075	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Medical testimony	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99078	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	1/1/1950	12/31/2999
99080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	1/1/1950	12/31/2999
99080	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	1/1/1950	12/31/2999
99082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unusual travel (eg, transportation and escort of patient)	1/1/1950	12/31/2999
99082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unusual travel (eg, transportation and escort of patient)	1/1/1950	12/31/2999
99175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison	1/1/1950	12/31/2999
99199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special service, procedure or report	4/16/2015	12/31/2999
99360	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99429	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted preventive medicine service	1/1/1950	12/31/2999
99450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates.	1/1/1950	12/31/2999
99455	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99456	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	1/1/1950	12/31/2999
99499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted evaluation and management service	1/1/1950	12/31/2999
99509	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home visit for assistance with activities of daily living and personal care	1/1/2021	12/31/2999
99600	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted home visit service or procedure	1/1/1950	12/31/2999
0054T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
0055T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0071T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata including MR guidance; total leiomyomata volume less than 200 cc of tissue	12/1/2023	12/31/2999
0072T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	12/1/2023	12/31/2999
0076T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of extracranial vertebral artery stent(s) including radiologic supervision and interpretation open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	11/15/2006	12/31/2025
0101T	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	7/1/2005	12/31/2999
0105U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nephrology (chronic kidney disease) multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A receptor superfamily 2 (TNFR1 TNFR2) and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data including APOL1 genotype if available and plasma (isolated fresh or frozen) algorithm reported as probability score for rapid kidney function decline (RKFD)	10/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0200T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous sacral augmentation (sacroplasty) unilateral injection(s) including the use of a balloon or mechanical device when used 1 or more needles includes imaging guidance and bone biopsy when performed	11/1/2019	12/31/2025
0201T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous sacral augmentation (sacroplasty) bilateral injections including the use of a balloon or mechanical device when used 2 or more needles includes imaging guidance and bone biopsy when performed	11/1/2019	12/31/2025
0238T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal peripheral atherectomy open or percutaneous including radiological supervision and interpretation; iliac artery each vessel	1/1/2026	12/31/2999
0253T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device without extraocular reservoir internal approach into the suprachoroidal space	1/1/2011	12/31/2999
0266T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement unilateral or bilateral lead placement intra-operative interrogation programming and repositioning when performed)	10/1/2022	12/31/2999
0267T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation or replacement of carotid sinus baroreflex activation device; lead only unilateral (includes intra-operative interrogation programming and repositioning when performed)	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0268T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation programming and repositioning when performed)	8/16/2019	12/31/2999
0269T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement unilateral or bilateral lead placement intra-operative interrogation programming and repositioning when performed)	10/1/2022	12/31/2999
0270T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of carotid sinus baroreflex activation device; lead only unilateral (includes intra-operative interrogation programming and repositioning when performed)	10/1/2022	12/31/2999
0271T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation programming and repositioning when performed)	10/1/2022	12/31/2999
0273T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) carotid sinus baroreflex activation 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	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0308T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	7/1/2012	12/31/2999
0331T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging planar qualitative and quantitative assessment;	4/1/2021	12/31/2999
0332T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging planar qualitative and quantitative assessment; with tomographic SPECT	8/16/2019	12/31/2999
0338T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter renal sympathetic denervation percutaneous approach including arterial puncture selective catheter placement(s) renal artery(ies) fluoroscopy contrast injection(s) intraprocedural roadmapping and radiological supervision and interpretation including pressure gradient measurements flush aortogram and diagnostic renal angiography when performed; unilateral	10/15/2025	12/31/2999
0339T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter renal sympathetic denervation percutaneous approach including arterial puncture selective catheter placement(s) renal artery(ies) fluoroscopy contrast injection(s) intraprocedural roadmapping and radiological supervision and interpretation including pressure gradient measurements flush aortogram and diagnostic renal angiography when performed; bilateral	10/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0342T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	3/1/2025	12/31/2999
0345T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	2/15/2016	12/31/2999
0352T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Optical coherence tomography of breast or axillary lymph node excised tissue each specimen; interpretation and report real-time or referred	11/1/2019	12/31/2025
0354T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Optical coherence tomography of breast surgical cavity; interpretation and report real-time or referred	11/1/2019	12/31/2025
0402T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Collagen cross-linking of cornea including removal of the corneal epithelium when performed and intraoperative pachymetry when performed	11/1/2017	12/31/2999
0407U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nephrology (diabetic chronic kidney disease [CKD]) multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1) soluble tumor necrosis receptor 2 (sTNFR2) and kidney injury molecule 1 (KIM-1) combined with clinical data plasma algorithm reported as risk for progressive decline in kidney function	10/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0408T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	3/15/2024	12/31/2999
0409T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; pulse generator only	3/15/2024	12/31/2999
0410T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; atrial electrode only	3/15/2024	12/31/2999
0411T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; ventricular electrode only	3/15/2024	12/31/2999
0412T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; pulse generator only	3/15/2024	12/31/2999
0413T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0414T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	3/15/2024	12/31/2999
0415T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	3/15/2024	12/31/2999
0416T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	3/15/2024	12/31/2999
0417T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis including review and report implantable cardiac contractility modulation system	3/15/2024	12/31/2999
0418T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis review and report includes connection recording and disconnection per patient encounter implantable cardiac contractility modulation system	3/15/2024	12/31/2999
0422T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tactile breast imaging by computer-aided tactile sensors unilateral or bilateral	11/1/2019	12/31/2025
0440T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation percutaneous cryoablation includes imaging guidance; upper extremity distal/peripheral nerve	5/1/2024	12/31/2025
0441T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation percutaneous cryoablation includes imaging guidance; lower extremity distal/peripheral nerve	5/1/2024	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0442T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation percutaneous cryoablation includes imaging guidance; nerve plexus or other truncal nerve (eg brachial plexus pudendal nerve)	5/1/2024	12/31/2025
0449T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of aqueous drainage device without extraocular reservoir internal approach into the subconjunctival space; initial device	1/1/2020	12/31/2999
0450T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of aqueous drainage device without extraocular reservoir internal approach into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	5/1/2021	12/31/2999
0474T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device with creation of intraocular reservoir internal approach into the supraciliary space	7/1/2017	12/31/2999
0484T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg thoracotomy transapical)	9/1/2020	12/31/2999
0494T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system including decannulation separation from the perfusion system and cold preservation of the allograft prior to implantation when performed	9/1/2020	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0495T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional including physiological and laboratory assessment (eg pulmonary artery flow pulmonary artery pressure left atrial pressure pulmonary vascular resistance mean/peak and plateau airway pressure dynamic compliance and perfusate gas analysis) including bronchoscopy and X ray when performed; first two hours in sterile field	9/1/2020	12/31/2025
0496T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional including physiological and laboratory assessment (eg pulmonary artery flow pulmonary artery pressure left atrial pressure pulmonary vascular resistance mean/peak and plateau airway pressure dynamic compliance and perfusate gas analysis) including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	9/1/2020	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0505T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous femoral-popliteal arterial revascularization with transcatheter placement of intravascular stent graft(s) and closure by any method including percutaneous or open vascular access ultrasound guidance for vascular access when performed all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention all associated radiological supervision and interpretation when performed with crossing of the occlusive lesion in an extraluminal fashion	1/1/2026	12/31/2999
0516T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing including device interrogation and programming and imaging supervision and interpretation when performed; electrode only	10/1/2019	12/31/2999
0517T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing including device interrogation and programming and imaging supervision and interpretation when performed; both components of pulse generator (battery and transmitter) only	10/1/2019	12/31/2999
0524T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein open or percutaneous including all vascular access catheter manipulation diagnostic imaging imaging guidance and monitoring	10/1/2019	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0529T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis review and report	10/1/2019	12/31/2999
0544T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter mitral valve annulus reconstruction with implantation of adjustable annulus reconstruction device percutaneous approach including transseptal puncture	10/1/2022	12/31/2999
0545T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device percutaneous approach	9/1/2023	12/31/2025
0552T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low-level laser therapy dynamic photonic and dynamic thermokinetic energies provided by a physician or other qualified health care professional	12/15/2020	12/31/2999
0561T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	11/1/2024	12/31/2999
0562T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	11/1/2024	12/31/2999
0569T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair percutaneous approach; initial prosthesis	11/15/2025	12/31/2999
0570T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	11/15/2025	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0576T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode with analysis review and report by a physician or other qualified health care professional includes connection recording and disconnection per patient encounter	2/15/2025	12/31/2999
0577T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation induction of arrhythmia evaluation of sensing for arrhythmia termination and programming or reprogramming of sensing or therapeutic parameters)	2/15/2025	12/31/2999
0578T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote) up to 90 days substernal lead implantable cardioverter-defibrillator system with interim analysis review(s) and report(s) by a physician or other qualified health care professional	2/15/2025	12/31/2999
0579T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote) up to 90 days substernal lead implantable cardioverter-defibrillator system remote data acquisition(s) receipt of transmissions and technician review technical support and distribution of results	2/15/2025	12/31/2999
0580T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of substernal implantable defibrillator pulse generator only	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0587T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator including analysis programming and imaging guidance when performed posterior tibial nerve	3/1/2021	12/31/2999
0588T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator including analysis programming and imaging guidance when performed posterior tibial nerve	3/1/2021	12/31/2999
0589T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional posterior tibial nerve 1-3 parameters	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0590T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional posterior tibial nerve 4 or more parameters	3/1/2021	12/31/2999
0596T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie voiding prosthesis); initial insertion including urethral measurement	11/15/2023	12/31/2999
0597T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie voiding prosthesis); replacement	11/15/2023	12/31/2999
0600T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation irreversible electroporation; 1 or more tumors per organ other than liver or prostate including imaging guidance when performed percutaneous	9/1/2023	12/31/2999
0601T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation irreversible electroporation; 1 or more tumors per organ including fluoroscopic and ultrasound guidance when performed open	9/1/2023	12/31/2999
0614T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of substernal implantable defibrillator pulse generator	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0632T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries including right heart catheterization pulmonary artery angiography and all imaging guidance	7/1/2023	12/31/2025
0643T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed arterial approach	7/1/2021	12/31/2025
0645T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter implantation of coronary sinus reduction device including vascular access and closure right heart catheterization venous angiography coronary sinus angiography imaging guidance and supervision and interpretation when performed	7/1/2021	12/31/2025
0646T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve percutaneous approach including right heart catheterization temporary pacemaker insertion and selective right ventricular or right atrial angiography when performed	11/15/2025	12/31/2999
0650T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis review and report by a physician or other qualified health care professional	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0659T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction including catheter placement imaging guidance (eg fluoroscopy) angiography and radiologic supervision and interpretation	3/1/2025	12/31/2025
0692T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic ultrafiltration	5/1/2024	12/31/2999
0716T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	5/15/2025	12/31/2025
0720T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous electrical nerve field stimulation cranial nerves without implantation	11/1/2024	12/31/2999
0740T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	9/1/2023	12/31/2999
0741T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software data collection transmission and storage each 30 days	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0745T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	6/15/2023	12/31/2025
0747T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy arrhythmia	6/15/2023	12/31/2025
0765T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg low-ejection fraction pulmonary hypertension hypertrophic cardiomyopathy); related to previously performed electrocardiogram	6/15/2023	12/31/2025
0784T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array spinal with integrated neurostimulator including imaging guidance when performed	3/15/2024	12/31/2999
0785T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array spinal with integrated neurostimulator	3/15/2024	12/31/2999
0786T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array sacral with integrated neurostimulator including imaging guidance when performed	3/15/2024	12/31/2999
0787T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array sacral with integrated neurostimulator	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0788T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional spinal cord or sacral nerve 1-3 parameters	3/15/2024	12/31/2999
0789T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional spinal cord or sacral nerve 4 or more parameters	3/15/2024	12/31/2999
0793T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries including right heart catheterization pulmonary artery angiography and all imaging guidance	7/1/2023	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0795T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter insertion of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; complete system (ie right atrial and right ventricular pacemaker components)	7/1/2023	12/31/2999
0796T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter insertion of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	7/1/2023	12/31/2999
0797T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter insertion of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0798T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) when performed; complete system (ie right atrial and right ventricular pacemaker components)	7/1/2023	12/31/2999
0799T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) when performed; right atrial pacemaker component	7/1/2023	12/31/2999
0800T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0801T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; dual-chamber system (ie right atrial and right ventricular pacemaker components)	7/1/2023	12/31/2999
0802T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; right atrial pacemaker component	7/1/2023	12/31/2999
0803T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography right ventriculography femoral venography) and device evaluation (eg interrogation or programming) when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0804T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values with analysis review and report by a physician or other qualified health care professional leadless pacemaker system in dual cardiac chambers	7/1/2023	12/31/2999
0805T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie caval valve implantation [CAVI]); percutaneous femoral vein approach	7/1/2023	12/31/2025
0806T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie caval valve implantation [CAVI]); open femoral vein approach	7/1/2023	12/31/2025
0810T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subretinal injection of a pharmacologic agent including vitrectomy and 1 or more retinotomies	7/1/2023	12/31/2999
0811T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	1/1/2024	12/31/2999
0812T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0823T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter insertion of permanent single-chamber leadless pacemaker right atrial including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography and/or right ventriculography femoral venography cavography) and device evaluation (eg interrogation or programming) when performed	5/15/2024	12/31/2999
0824T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal of permanent single-chamber leadless pacemaker right atrial including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography and/or right ventriculography femoral venography cavography) when performed	5/15/2024	12/31/2999
0825T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker right atrial including imaging guidance (eg fluoroscopy venous ultrasound right atrial angiography and/or right ventriculography femoral venography cavography) and device evaluation (eg interrogation or programming) when performed	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0826T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis review and report by a physician or other qualified health care professional leadless pacemaker system in single-cardiac chamber	5/15/2024	12/31/2999
0859T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Noncontact near-infrared spectroscopy (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation) other than for screening for peripheral arterial disease image acquisition interpretation and report; each additional anatomic site (List separately in addition to code for primary procedure)	5/15/2025	12/31/2025
0861T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	3/15/2024	12/31/2999
0862T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing including device interrogation and programming; battery component only	3/15/2024	12/31/2999
0863T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing including device interrogation and programming; transmitter component only	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0947T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS) stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target intracranial including stereotactic navigation and frame placement when performed	2/15/2025	12/31/2999
9701A	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	NON-PRESCRIPTION DRUGS	1/1/1950	12/31/2999
A0021	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service outside state per mile transport (medicaid only)	9/24/2012	12/31/2999
A0080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	1/1/2021	12/31/2999
A0090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	1/1/2021	12/31/2999
A0100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; taxi	1/1/2021	12/31/2999
A0110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and bus, intra or inter state carrier	1/1/2021	12/31/2999
A0120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	1/1/2021	12/31/2999
A0130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: wheel-chair van	1/1/2021	12/31/2999
A0140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and air travel (private or commercial) intra or inter state	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: per mile - case worker or social worker	1/1/2021	12/31/2999
A0170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation ancillary: parking fees, tolls, other	1/1/2021	12/31/2999
A0180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging-recipient	1/1/2021	12/31/2999
A0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-recipient	1/1/2021	12/31/2999
A0200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging escort	1/1/2021	12/31/2999
A0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-escort	1/1/2021	12/31/2999
A0426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service advanced life support non-emergency transport level 1 (als 1)	9/15/2014	12/31/2999
A0431	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service conventional air services transport one way (rotary wing)	11/15/2007	12/31/2999
A0436	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rotary wing air mileage per statute mile	1/1/1950	12/31/2999
A0888	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	1/1/2021	12/31/2999
A0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ambulance service	1/1/1950	12/31/2999
A4100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-sheet form skin substitute fda cleared as a device not otherwise specified (list in addition to primary procedure)	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol or peroxide, per pint	1/1/1950	12/31/2999
A4246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Betadine or phisohex solution, per pint	1/1/1950	12/31/2999
A4247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Betadine or iodine swabs/wipes, per box	1/1/1950	12/31/2999
A4335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incontinence supply; miscellaneous	1/1/1950	12/31/2999
A4335	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Incontinence supply; miscellaneous	10/24/2019	12/31/2999
A4341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Indwelling intraurethral drainage device with valve patient inserted replacement only each	11/15/2023	12/31/2999
A4342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessories for patient inserted indwelling intraurethral drainage device with valve replacement only each	11/15/2023	12/31/2999
A4421	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Ostomy supply; miscellaneous	1/1/1950	12/31/2999
A4450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tape, non-waterproof, per 18 square inches	1/1/1950	12/31/2999
A4452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tape, waterproof, per 18 square inches	1/1/1950	12/31/2999
A4458	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enema bag with tubing, reusable	1/1/1950	12/31/2999
A4465	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-elastic binder for extremity	1/1/1950	12/31/2999
A4468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exsufflation belt includes all supplies and accessories	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4490	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings above knee length, each	1/1/1950	12/31/2999
A4495	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings thigh length, each	1/1/1950	12/31/2999
A4500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings below knee length, each	1/1/1950	12/31/2999
A4510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings full length, each	1/1/1950	12/31/2999
A4520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	1/1/2005	12/31/2999
A4540	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Distal transcutaneous electrical nerve stimulator stimulates peripheral nerves of the upper arm	1/1/2026	12/31/2999
A4541	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monthly supplies for use of device coded at e0733	2/15/2024	12/31/2999
A4545	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies and accessories for external tibial nerve stimulator (e.g. socks gel pads electrodes etc.) needed for one month	2/15/2025	12/31/2999
A4554	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Disposable underpads, all sizes	1/1/1950	12/31/2999
A4555	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrode/transducer for use with electrical stimulation device used for cancer treatment replacement only	6/15/2017	12/31/2999
A4558	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE (E.G., TENS, NMES), PER OZ	1/1/1950	12/31/2999
A4593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system adjunct to rehabilitation therapy regime controller	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4594	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system adjunct to rehabilitation therapy regime mouthpiece each	5/15/2025	12/31/2999
A4638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement battery for patient-owned ear pulse generator each	5/1/2024	12/31/2999
A4641	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, DIAGNOSTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A4649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Surgical supply; miscellaneous	1/1/1950	12/31/2999
A4890	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Contracts, repair and maintenance, for hemodialysis equipment	1/1/1950	12/31/2999
A4913	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dialysis supplies, not otherwise specified	1/1/1950	12/31/2999
A4927	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gloves, non-sterile, per 100	1/1/1950	12/31/2999
A4931	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oral thermometer, reusable, any type, each	1/1/1950	12/31/2999
A4932	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rectal thermometer, reusable, any type, each	1/1/1950	12/31/2999
A5507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	1/1/1950	12/31/2999
A6216	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without adhesive border, each dressing	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A6217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But less than or equal to 48 sq. In. , without adhesive border, each dressing	1/1/1950	12/31/2999
A6218	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In. , without adhesive border, each dressing	1/1/1950	12/31/2999
A6261	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6262	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6512	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compression burn garment, not otherwise classified	10/24/2019	12/31/2999
A6519	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for nighttime use, each	4/1/2025	12/31/2999
A6530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, below knee, 18-30 mmhg, each	1/1/2006	12/31/2999
A6531	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each	1/1/2006	12/31/2999
A6533	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, thigh length, 18-30 mmhg, each	1/1/2006	12/31/2999
A6534	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, thigh length, 30-40 mmhg, each	1/1/2006	12/31/2999
A6536	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, full length/chap style, 18-30 mmhg, each	1/1/2006	12/31/2999
A6537	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, full length/chap style, 30-40 mmhg, each	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A6539	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, waist length, 18-30 mmhg, each	1/1/2006	12/31/2999
A6540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, waist length, 30-40 mmhg, each	1/1/2006	12/31/2999
A6544	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression stocking, garter belt	1/1/2006	12/31/2999
A6549	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gradient compression garment, not otherwise specified, for daytime use, each	1/1/2006	12/31/2999
A6549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for daytime use, each	10/24/2019	12/31/2999
A9150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-prescription drugs	1/1/1950	12/31/2999
A9152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9152	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9153	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9153	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-covered item or service	1/1/1950	12/31/2999
A9273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	1/1/2011	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9279	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED	1/1/2007	12/31/2999
A9280	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alert or alarm device, not otherwise classified	1/1/1950	12/31/2999
A9282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	WIG, ANY TYPE, EACH	1/1/2006	12/31/2999
A9291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prescription digital cognitive and/or behavioral therapy fda cleared per course of treatment	2/1/2024	12/31/2999
A9300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Exercise equipment	1/1/1950	12/31/2999
A9579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, NOT OTHERWISE SPECIFIED (NOS), per ml	10/24/2019	12/31/2999
A9597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9598	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	NON-RADIOACTIVE CONTRAST IMAGING MATERIAL, NOT OTHERWISE CLASSIFIED, PER STUDY	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, THERAPEUTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A9900	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply, accessory, and/or service component of another hcpcs code	4/16/2015	12/31/2999
A9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply or accessory, not otherwise specified	1/1/1950	12/31/2999
B4102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	1/1/2005	12/31/2999
B4103	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	1/1/2005	12/31/2999
B4104	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	1/1/2005	12/31/2999
B4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	In-line cartridge containing digestive enzyme(s) for enteral feeding each	10/1/2019	12/31/2999
B4149	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/1950	12/31/2999
B4152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/1950	12/31/2999
B4154	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999
B4158	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4159	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2005	12/31/2999
B4160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2005	12/31/2999
B4164	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix	1/1/1950	12/31/2999
B9998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for enteral supplies	4/16/2015	12/31/2999
B9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for parenteral supplies	1/1/1950	12/31/2999
C1062	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravertebral body fracture augmentation with implant (e.g. metal polymer)	3/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pacemaker leadless dual chamber (right atrial and right ventricular implantable components) rate-responsive including all necessary components for implantation	7/1/2024	12/31/2999
C1735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s) intravascular for renal denervation radiofrequency including all single use system components	10/15/2025	12/31/2999
C1736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s) intravascular for renal denervation ultrasound including all single use system components	10/15/2025	12/31/2999
C1737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Joint fusion and fixation device(s) sacroiliac and pelvis including all system components (implantable)	3/1/2025	12/31/2999
C1761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter transluminal intravascular lithotripsy coronary	7/1/2021	12/31/2999
C1764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Event recorder cardiac (implantable)	1/1/2019	12/31/2999
C1776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Joint device (implantable)	6/1/2017	12/31/2999
C1778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead neurostimulator (implantable)	3/15/2024	12/31/2999
C1783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ocular implant aqueous drainage assist device	3/15/2015	12/31/2999
C1817	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Septal defect implant system intracardiac	4/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integrated keratoprosthesis	1/1/2015	12/31/2999
C1820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator neurostimulator (implantable) with rechargeable battery and charging system	7/15/2023	12/31/2999
C1821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	1/15/2025	12/31/2999
C1822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator neurostimulator (implantable) high frequency with rechargeable battery and charging system	1/1/2022	12/31/2999
C1824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator cardiac contractility modulation (implantable)	3/15/2024	12/31/2999
C1825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator neurostimulator (implantable) non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	2/1/2021	12/31/2999
C1826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator neurostimulator (implantable) includes closed feedback loop leads and all implantable components with rechargeable battery and charging system	7/1/2023	12/31/2999
C1833	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor cardiac including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2999
C1889	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Implantable/insertable device, not otherwise classified	1/1/2017	12/31/2999
C2624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable wireless pulmonary artery pressure sensor with delivery catheter including all system components	8/16/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C2698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999
C2699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, NON-STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999
C5271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to trunk arms legs total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4/1/2023	12/31/2999
C5272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to trunk arms legs total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area or part thereof (list separately in addition to code for primary procedure)	4/1/2023	12/31/2999
C5273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to trunk arms legs total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area or 1% of body area of infants and children	4/1/2023	12/31/2999
C5274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to trunk arms legs total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof or each additional 1% of body area of infants and children or part thereof (list separately in addition to code for primary procedure)	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C5275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4/1/2023	12/31/2999
C5276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area or part thereof (list separately in addition to code for primary procedure)	4/1/2023	12/31/2999
C5277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area or 1% of body area of infants and children	4/1/2023	12/31/2999
C5278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of low cost skin substitute graft to face scalp eyelids mouth neck ears orbits genitalia hands feet and/or multiple digits total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof or each additional 1% of body area of infants and children or part thereof (list separately in addition to code for primary procedure)	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C7531	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral popliteal artery(ies) unilateral with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention including radiological supervision and interpretation	1/1/2026	12/31/2999
C7534	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral popliteal artery(ies) unilateral with atherectomy includes angioplasty within the same vessel when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention including radiological supervision and interpretation	1/1/2026	12/31/2999
C7535	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous femoral popliteal artery(ies) unilateral with transluminal stent placement(s) includes angioplasty within the same vessel when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention including radiological supervision and interpretation	1/1/2026	12/31/2999
C9399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unclassified drugs or biologicals	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9734	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation/therapeutic intervention other than uterine leiomyomata with magnetic resonance (MR) guidance	10/15/2014	12/31/2999
C9739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with insertion of transprostatic implant; 1 to 3 implants	12/1/2015	12/31/2999
C9740	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with insertion of transprostatic implant; 4 or more implants	12/1/2015	12/31/2999
C9764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous any vessel(s); with intravascular lithotripsy includes angioplasty within the same vessel(s) when performed	5/15/2021	12/31/2999
C9765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous any vessel(s); with intravascular lithotripsy and transluminal stent placement(s) includes angioplastyÂ within the same vessel(s) when performed	5/15/2021	12/31/2999
C9766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous any vessel(s); with intravascular lithotripsy and atherectomy includes angioplasty within the same vessel(s) when performed	5/15/2021	12/31/2999
C9767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization endovascular open or percutaneous any vessel(s); with intravascular lithotripsy and transluminal stent placement(s) and atherectomy includes angioplasty within the same vessel(s) when performed	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blinded procedure for new york heart association (nyha) class ii or iii heart failure or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g. mononuclear) or placebo control autologous bone marrow harvesting and preparation for transplantation left heart catheterization including ventriculography all laboratory services and all imaging with or without guidance (e.g. transthoracic echocardiography ultrasound fluoroscopy) performed in an approved investigational device exemption (ide) study	2/1/2024	12/31/2999
C9785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic outlet reduction gastric pouch application with endoscopy and intraluminal tube insertion if performed including all system and tissue anchoring components	1/1/2026	12/31/2999
C9793	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3d predictive model generation for pre-planning of a cardiac procedure using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report	8/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nerve cryoablation probe (e.g. cryoice cryosphere cryosphere max cryoice cryosphere cryoice cryo2) including probe and all disposable system components non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa 2023)	3/1/2025	12/31/2999
C9809	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryoablation needle (e.g. iovera system) including needle/tip and all disposable system components non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa 2023)	3/1/2025	12/31/2999
C9898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiolabeled product provided during a hospital inpatient stay	1/1/2012	12/31/2999
C9899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	IMPLANTED PROSTHETIC DEVICE, PAYABLE ONLY FOR INPATIENTS WHO DO NOT HAVE INPATIENT COVERAGE	1/1/2012	12/31/2999
D0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified diagnostic procedure, by report	10/24/2019	12/31/2999
D1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified preventive procedure, by report	10/24/2019	12/31/2999
D2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified restorative procedure, by report	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D3410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apicoectomy - anterior	1/1/1950	12/31/2999
D3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified endodontic procedure, by report	10/24/2019	12/31/2999
D4999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified periodontal procedure, by report	10/24/2019	12/31/2999
D5899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified removable prosthodontic procedure, by report	10/24/2019	12/31/2999
D5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified maxillofacial prosthesis, by report	10/24/2019	12/31/2999
D6199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified implant procedure, by report	10/24/2019	12/31/2999
D6999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified fixed prosthodontic procedure, by report	10/24/2019	12/31/2999
D7210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1/1/1950	12/31/2999
D7220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of impacted tooth - soft tissue	1/1/1950	12/31/2999
D7230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of impacted tooth - partially bony	1/1/1950	12/31/2999
D7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified oral surgery procedure, by report	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D8210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable appliance therapy	1/1/1950	12/31/2999
D8220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fixed appliance therapy	1/1/1950	12/31/2999
D8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified orthodontic procedure, by report	10/24/2019	12/31/2999
D9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified adjunctive procedure, by report	1/1/1950	12/31/2999
E0152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Walker battery powered wheeled folding adjustable or fixed height	5/15/2025	12/31/2999
E0162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sitz bath chair	1/1/1950	12/31/2999
E0183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered pressure reducing underlay/pad alternating with pump includes heavy duty	10/1/2022	12/31/2999
E0187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Water pressure mattress	10/1/2006	12/31/2999
E0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	2/1/2010	12/31/2999
E0201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile contracture device manual greater than 3 lbs traction force	5/15/2025	12/31/2999
E0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electric heat pad, standard	1/1/1950	12/31/2999
E0215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electric heat pad, moist	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Water circulating heat pad with pump	6/1/2006	12/31/2999
E0218	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fluid circulating cold pad with pump, any type	1/1/2021	12/31/2999
E0236	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pump for water circulating pad	1/1/2021	12/31/2999
E0240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath/shower chair, with or without wheels, any size	1/1/1950	12/31/2999
E0241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub wall rail, each	1/1/1950	12/31/2999
E0242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub rail, floor base	1/1/1950	12/31/2999
E0243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Toilet rail, each	1/1/1950	12/31/2999
E0244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Raised toilet seat	1/1/1950	12/31/2999
E0245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tub stool or bench	1/1/1950	12/31/2999
E0246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer tub rail attachment	1/1/1950	12/31/2999
E0247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer bench for tub or toilet with or without commode opening	1/1/1950	12/31/2999
E0248	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer bench, heavy duty, for tub or toilet with or without commode opening	1/1/1950	12/31/2999
E0249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	9/1/2006	12/31/2999
E0273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bed board	1/1/2021	12/31/2999
E0274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Over-bed table	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bed cradle any type	10/1/2006	12/31/2999
E0291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed fixed height without side rails without mattress	5/15/2014	12/31/2999
E0293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed variable height hi-lo without side rails without mattress	5/15/2014	12/31/2999
E0315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bed accessory: board, table, or support device, any type	1/1/2021	12/31/2999
E0316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety enclosure frame/canopy for use with hospital bed, any type	1/1/2021	12/31/2999
E0446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	10/24/2019	12/31/2999
E0462	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rocking bed with or without side rails	1/1/1950	12/31/2999
E0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle controlled by phone application	3/1/2024	12/31/2999
E0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle used in conjunction with the power source and control electronics unit controlled by phone application 90-day supply	3/1/2024	12/31/2999
E0530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic positional obstructive sleep apnea treatment with sensor includes all components and accessories any type	3/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable cardiac event recorder with memory activator and programmer	1/1/1950	12/31/2999
E0620	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Skin piercing device for collection of capillary blood, laser, each	1/1/1950	12/31/2999
E0625	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient lift, bathroom or toilet, not otherwise classified	12/21/2004	12/31/2999
E0652	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor segmental home model with calibrated gradient pressure	2/1/2006	12/31/2999
E0656	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR TRUNK	2/1/2025	12/31/2999
E0658	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor integrated 2 full arms and chest	1/1/2026	12/31/2999
E0659	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor integrated head neck and chest	1/1/2026	12/31/2999
E0667	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor full leg	2/1/2025	12/31/2999
E0676	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES) NOT OTHERWISE SPECIFIED	1/1/2007	12/31/2999
E0676	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	3/20/2019	12/31/2999
E0677	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment trunk	7/1/2023	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous tibial nerve stimulator controlled by phone application	2/15/2025	12/31/2999
E0738	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education include microprocessor all components and accessories	5/15/2025	12/31/2999
E0739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy includes all components and accessories motors microprocessors sensors	5/15/2025	12/31/2999
E0744	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromuscular stimulator for scoliosis	3/15/2024	12/31/2999
E0746	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electromyography (emg) biofeedback device	1/1/2006	12/31/2999
E0747	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator electrical non-invasive other than spinal applications	1/1/1950	12/31/2999
E0755	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electronic salivary reflex stimulator (intra-oral/non-invasive)	1/1/1950	12/31/2999
E0760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator low intensity ultrasound non-invasive	1/1/2026	12/31/2999
E0761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-thermal pulsed high frequency radiowaves high peak power electromagnetic energy treatment device	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulation device used for cancer treatment includes all accessories any type	6/15/2017	12/31/2999
E0769	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	1/1/2005	12/31/2999
E0770	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	1/1/2009	12/31/2999
E0920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame attached to bed includes weights	11/1/2005	12/31/2999
E0930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame free standing includes weights	11/1/2005	12/31/2999
E0946	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame dual with cross bars attached to bed (e. G. Balken 4 poster)	11/1/2005	12/31/2999
E0948	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fracture frame attachments for complex cervical traction	9/1/2020	12/31/2999
E0984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory power add-on to convert manual wheelchair to motorized wheelchair tiller control	1/1/1950	12/31/2999
E0985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory seat lift mechanism	3/15/2014	12/31/2999
E0986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory power assist system	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0988	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY LEVER-ACTIVATED WHEEL DRIVE PAIR	3/15/2014	12/31/2999
E1005	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory power seatng system recline only with power shear reduction	9/24/2012	12/31/2999
E1006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory power seating system combination tilt and recline without shear reduction	6/1/2006	12/31/2999
E1008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory power seating system combination tilt and recline with power shear reduction	6/1/2006	12/31/2999
E1009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory addition to power seating system mechanically linked leg elevation system including pushrod and leg rest each	6/1/2006	12/31/2999
E1010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory addition to power seating system power leg elevation system including leg rest pair	6/1/2006	12/31/2999
E1012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory addition to power seating system center mount power elevating leg rest/platform complete system any type each	1/1/2016	12/31/2999
E1022	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair transportation securement system any type includes all components and accessories	4/1/2025	12/31/2999
E1023	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair transit securement system includes all components and accessories	4/1/2025	12/31/2999
E1083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair fixed full length arms swing away detachable elevating leg rest	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1085	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair fixed full length arms swing away detachable foot rests	3/15/2014	12/31/2999
E1087	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair fixed full length arms swing away detachable elevating leg rests	3/15/2014	12/31/2999
E1170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair fixed full length arms swing away detachable elevating legrests	3/15/2014	12/31/2999
E1171	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair fixed full length arms without footrests or legrest	3/15/2014	12/31/2999
E1172	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair detachable arms (desk or full length) without footrests or legrest	3/15/2014	12/31/2999
E1195	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair fixed full length arms swing away detachable elevating legrests	1/1/1950	12/31/2999
E1227	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special height arms for wheelchair	3/15/2014	12/31/2999
E1228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special back height for wheelchair	3/15/2014	12/31/2999
E1229	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair pediatric size tilt-in-space rigid adjustable with seating system	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1239	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR PEDIATRIC SIZE NOT OTHERWISE SPECIFIED	3/15/2014	12/31/2999
E1239	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair fixed full length arms elevating legrest	1/1/1950	12/31/2999
E1300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, portable (overtub type)	1/1/1950	12/31/2999
E1301	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Whirlpool tub walk-in portable	3/15/2024	12/31/2999
E1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, non-portable (built-in type)	1/1/1950	12/31/2999
E1355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Stand/rack	1/1/1950	12/31/2999
E1399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Durable medical equipment, miscellaneous	1/15/2015	12/31/2999
E1699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dialysis equipment, not otherwise specified	10/24/2019	12/31/2999
E1700	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Jaw motion rehabilitation system	1/1/1950	12/31/2999
E1701	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	1/1/1950	12/31/2999
E1702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1905	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Virtual reality cognitive behavioral therapy device (cbt) including pre-programmed therapy software	5/15/2025	12/31/2999
E2120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	5/1/2024	12/31/2999
E2207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	6/1/2006	12/31/2999
E2216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY FOAM FILLED PROPULSION TIRE ANY SIZE EACH	6/1/2006	12/31/2999
E2295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY FOR PEDIATRIC SIZE WHEELCHAIR DYNAMIC SEATING FRAME ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	1/1/2009	12/31/2999
E2298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Complex rehabilitative power wheelchair accessory power seat elevation system any type	4/1/2024	12/31/2999
E2301	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory power standing system any type	9/1/2020	12/31/2999
E2310	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory electronic connection between wheelchair controller and one power seating system motor including all related electronics indicator feature mechanical function selection switch and fixed mounting hardware	9/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory electronic connection between wheelchair controller and two or more power seating system motors including all related electronics indicator feature mechanical function selection switch and fixed mounting hardware	9/15/2007	12/31/2999
E2312	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY HAND OR CHIN CONTROL INTERFACE MINI-PROPORTIONAL	1/1/2008	12/31/2999
E2313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER	1/1/2008	12/31/2999
E2321	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory hand control interface remote joystick nonproportional including all related electronics mechanical stop switch and fixed mounting hardware	3/15/2014	12/31/2999
E2322	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory hand control interface multiple mechanical switches nonproportional including all related electronics mechanical stop switch and fixed mounting hardware	6/1/2006	12/31/2999
E2323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory specialty joystick handle for hand control interface prefabricated	6/1/2006	12/31/2999
E2324	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory chin cup for chin control interface	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory sip and puff interface nonproportional including all related electronics mechanical stop switch and manual swingaway mounting hardware	6/1/2006	12/31/2999
E2326	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory breath tube kit for sip and puff interface	6/1/2006	12/31/2999
E2327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory head control interface mechanical proportional including all related electronics mechanical direction change switch and fixed mounting hardware	6/1/2006	12/31/2999
E2328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory head control or extremity control interface electronic proportional including all related electronics and fixed mounting hardware	6/1/2006	12/31/2999
E2329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory head control interface contact switch mechanism nonproportional including all related electronics mechanical stop switch mechanical direction change switch head array and fixed mounting hardware	6/1/2006	12/31/2999
E2330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory head control interface proximity switch mechanism nonproportional including all related electronics mechanical stop switch mechanical direction change switch head array and fixed mounting hardware	6/1/2006	12/31/2999
E2331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory attendant control proportional including all related electronics and fixed mounting hardware	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory nonstandard seat frame width 20-23 inches	6/1/2006	12/31/2999
E2341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory nonstandard seat frame width 24-27 inches	6/1/2006	12/31/2999
E2342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory nonstandard seat frame depth 20 or 21 inches	6/1/2006	12/31/2999
E2343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory nonstandard seat frame depth 22-25 inches	6/1/2006	12/31/2999
E2351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory electronic interface to operate speech generating device using power wheelchair control interface	6/1/2006	12/31/2999
E2358	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY GROUP 34 NON-SEALED LEAD ACID BATTERY EACH	1/1/2012	12/31/2999
E2359	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY GROUP 34 SEALED LEAD ACID BATTERY EACH (E.G. GEL CELL ABSORBED GLASSMAT)	1/1/2012	12/31/2999
E2360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory 22 nf non-sealed lead acid battery each	6/1/2006	12/31/2999
E2361	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory 22nf sealed lead acid battery each (e. G. Gel cell absorbed glassmat)	6/1/2006	12/31/2999
E2362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory group 24 non-sealed lead acid battery each	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2363	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory group 24 sealed lead acid battery each (e. G. Gel cell absorbed glassmat)	6/1/2006	12/31/2999
E2364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory u-1 non-sealed lead acid battery each	6/1/2006	12/31/2999
E2365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory u-1 sealed lead acid battery each (e. G. Gel cell absorbed glassmat)	6/1/2006	12/31/2999
E2366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory battery charger single mode for use with only one battery type sealed or non-sealed each	6/1/2006	12/31/2999
E2367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory battery charger dual mode for use with either battery type sealed or non-sealed each	6/1/2006	12/31/2999
E2371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY GROUP 27 SEALED LEAD ACID BATTERY (E.G. GEL CELL ABSORBED GLASSMAT) EACH	6/1/2006	12/31/2999
E2372	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY GROUP 27 NON-SEALED LEAD ACID BATTERY EACH	6/1/2006	12/31/2999
E2373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory hand or chin control interface compact remote joystick proportional including fixed mounting hardware	3/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2374	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY HAND OR CHIN CONTROL INTERFACE STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER) PROPORTIONAL INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE REPLACEMENT ONLY	3/15/2014	12/31/2999
E2375	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY NON-EXPANDABLE CONTROLLER INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE REPLACEMENT ONLY	3/15/2014	12/31/2999
E2376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY EXPANDABLE CONTROLLER INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE REPLACEMENT ONLY	3/15/2014	12/31/2999
E2377	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY EXPANDABLE CONTROLLER INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE UPGRADE PROVIDED AT INITIAL ISSUE	3/15/2014	12/31/2999
E2397	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY LITHIUM-BASED BATTERY EACH	1/1/2008	12/31/2999
E2500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device digitized speech using pre-recorded messages less than or equal to 8 minutes recording time	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2502	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device digitized speech using pre-recorded messages greater than 8 minutes but less than or equal to 20 minutes recording time	1/1/1950	12/31/2999
E2504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device digitized speech using pre-recorded messages greater than 20 minutes but less than or equal to 40 minutes recording time	1/1/1950	12/31/2999
E2506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device digitized speech using pre-recorded messages greater than 40 minutes recording time	1/1/1950	12/31/2999
E2508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device synthesized speech requiring message formulation by spelling and access by physical contact with the device	1/1/1950	12/31/2999
E2510	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating device synthesized speech permitting multiple methods of message formulation and multiple methods of device access	1/1/1950	12/31/2999
E2511	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech generating software program for personal computer or personal digital assistant	1/1/1950	12/31/2999
E2512	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessory for speech generating device mounting system	1/1/1950	12/31/2999
E2513	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessory for speech generating device electromyographic sensor	2/15/2025	12/31/2999
E2599	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessory for speech generating device not otherwise classified	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Accessory for speech generating device, not otherwise classified	1/1/1950	12/31/2999
E2628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED RECLINING	3/15/2014	12/31/2999
E2629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	3/15/2014	12/31/2999
E2632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	3/15/2014	12/31/2999
E2633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT SUPINATOR	3/15/2014	12/31/2999
G0235	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Pet imaging, any site, not otherwise specified	10/24/2019	12/31/2999
G0276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	1/1/2015	12/31/2999
G0293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	1/1/1950	12/31/2999
G0341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous islet cell transplant includes portal vein catheterization and infusion	1/1/1950	12/31/2999
G0342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy for islet cell transplant includes portal vein catheterization and infusion	1/1/1950	12/31/2999
G0343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparotomy for islet cell transplant includes portal vein catheterization and infusion	1/1/1950	12/31/2999
G0429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g. as a result of highly active antiretroviral therapy.)	9/24/2012	12/31/2999
G2083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration includes 2 hours post-administration observation	8/1/2021	12/31/2999
G8395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	1/1/2008	12/31/2999
G8396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8397	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	1/1/2008	12/31/2999
G8399	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed	1/1/2008	12/31/2999
G8400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given	1/1/2008	12/31/2999
G8404	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	1/1/2008	12/31/2999
G8405	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	1/1/2008	12/31/2999
G8410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	1/1/2008	12/31/2999
G8415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION WAS NOT PERFORMED	1/1/2008	12/31/2999
G8416	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR	1/1/2008	12/31/2999
G8417	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented above normal parameters and a follow-up plan is documented	1/1/2008	12/31/2999
G8418	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented below normal parameters and a follow-up plan is documented	1/1/2008	12/31/2999
G8419	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	1/1/2008	12/31/2999
G8420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented within normal parameters and no follow-up plan is required	1/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented and no reason is given	1/1/2008	12/31/2999
G8427	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	1/1/2008	12/31/2999
G8428	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	1/1/2008	12/31/2999
G8430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status)	1/1/2008	12/31/2999
G8431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression is documented as being positive and a follow-up plan is documented	1/1/2008	12/31/2999
G8432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Depression screening not documented, reason not given	1/1/2008	12/31/2999
G8433	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression not completed, documented patient or medical reason	1/1/2008	12/31/2999
G8450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy prescribed	1/1/2008	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8477	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	1/1/2008	12/31/2999
G8478	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure measurement not performed or documented, reason not given	1/1/2008	12/31/2999
G8559	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	1/1/2010	12/31/2999
G8560	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	1/1/2010	12/31/2999
G8561	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE	1/1/2010	12/31/2999
G8562	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	1/1/2010	12/31/2999
G8563	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	1/1/2010	12/31/2999
G8564	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED)	1/1/2010	12/31/2999
G8565	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8566	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS MEASURE	1/1/2010	12/31/2999
G8567	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	1/1/2010	12/31/2999
G8568	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	1/1/2010	12/31/2999
G8569	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged postoperative intubation (> 24 hrs) required	1/1/2010	12/31/2999
G8570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged postoperative intubation (> 24 hrs) not required	1/1/2010	12/31/2999
G8575	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED DIALYSIS	1/1/2010	12/31/2999
G8576	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED	1/1/2010	12/31/2999
G8577	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	1/1/2010	12/31/2999
G8578	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	1/1/2010	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8598	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy used	1/1/2010	12/31/2999
G8599	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy not used, reason not given	1/1/2010	12/31/2999
G8600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well	1/1/2010	12/31/2999
G8601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention)	1/1/2010	12/31/2999
G8602	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given	1/1/2010	12/31/2999
G9012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Other specified case management service not elsewhere classified	10/24/2019	12/31/2999
G9050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9053	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9054	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9055	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	10/24/2019	12/31/2999
G9056	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9066	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9072	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9073	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9074	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9077	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9078	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9079	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9083	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9084	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9085	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9086	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9092	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9093	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9094	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9095	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9096	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9103	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9104	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9106	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9107	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9123	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9124	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9129	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	1/1/2006	12/31/2999
G9131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9132	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9133	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9134	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9137	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9138	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999
G9139	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48 HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS PREVENT TRANSFER; PAYMENT IS MADE ON EACH PERIOD UP TO 4 HOURS, AFTER THE FIRST 4 HOURS	1/1/2008	12/31/2999
H0046	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Mental health services, not otherwise specified	7/1/2008	12/31/2999
H0047	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alcohol and/or other drug abuse services, not otherwise specified	7/1/2008	12/31/2999
J0174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection lecanemab-irmb 1 mg	9/15/2023	12/31/2999
J0218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection olipudase alfa-rpcp 1 mg	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0219	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection avalglucosidase alfa-ngpt 4 mg	4/1/2022	12/31/2999
J0220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION ALGLUCOSIDASE ALFA 10 MG NOT OTHERWISE SPECIFIED	1/1/2008	12/31/2999
J0220	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J0222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection Patisiran 0.1 mg	7/1/2021	12/31/2999
J0248	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection remdesivir 1mg	5/1/2024	12/31/2999
J0256	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG	10/24/2019	12/31/2999
J0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection belatacept 1 mg	4/1/2024	12/31/2999
J0491	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection anifrolumab-fnia 1 mg	4/1/2022	12/31/2999
J0517	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection benralizumab 1 mg	1/1/2019	12/31/2999
J0585	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION ONABOTULINUMTOXINA 1 UNIT	1/1/1950	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1306	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection inclisiran 1 mg	7/1/2022	12/31/2999
J1307	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection crovalimab-akkz 10 mg	3/15/2025	12/31/2999
J1411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection etranacogene dezaparvovec-drlb per therapeutic dose	5/1/2023	12/31/2999
J1412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection valoctocogene roxaparvovec-rvox per ml containing nominal 2 x 10^13 vector genomes	2/15/2024	12/31/2999
J1413	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection delandistrogene moxeparvovec-rokl per therapeutic dose	2/15/2024	12/31/2999
J1426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection casimersen 10 mg	10/1/2021	12/31/2999
J1427	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection viltolarsen 10 mg	5/1/2021	12/31/2999
J1428	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection eteplirsen 10 mg	1/1/2018	12/31/2999
J1429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection golodirsen 10 mg	11/1/2020	12/31/2999
J1440	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fecal microbiota live - jslm 1 ml	6/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1551	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection immune globulin (cutaquig) 100 mg	7/1/2022	12/31/2999
J1554	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection immune globulin (asceniv) 500 mg	4/1/2021	12/31/2999
J1566	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, immune globulin, intravenous, lyophilized (e. G. Powder), not otherwise specified, 500 mg	10/24/2019	12/31/2999
J1576	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection immune globulin (panzyga) intravenous non-lyophilized (e.g. liquid) 500 mg	8/1/2023	12/31/2999
J1599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG	10/24/2019	12/31/2999
J1628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection guselkumab 1 mg	1/1/2025	12/31/2999
J1726	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, (makena), 10 mg	7/15/2023	12/31/2999
J1729	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	7/15/2023	12/31/2999
J1729	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	10/24/2019	12/31/2999
J1747	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection spesolimab-sbzo 1 mg	5/1/2023	12/31/2999
J1823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection inebilizumab-cdon 1 mg	3/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION LANREOTIDE 1 MG	4/1/2024	12/31/2999
J2267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection mirikizumab-mrkz 1 mg	8/1/2024	12/31/2999
J2353	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection octreotide depot form for intramuscular injection 1 mg	4/1/2024	12/31/2999
J2354	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection octreotide non-depot form for subcutaneous or intravenous injection 25 mcg	4/1/2024	12/31/2999
J2356	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection tezepelumab-ekko 1 mg	7/1/2022	12/31/2999
J2508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection pegunigalsidase alfa-iwxj 1 mg	2/15/2024	12/31/2999
J2782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection avacincaptad pegol 0.1 mg	7/15/2024	12/31/2999
J2787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Riboflavin 5'-phosphate ophthalmic solution up to 3 mL	9/1/2020	12/31/2999
J3032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection eptinezumab-jjmr 1 mg	11/15/2020	12/31/2999
J3111	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection romosozumab-aqqg 1 mg	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection teprotumumab-trbw 10 mg	11/1/2020	12/31/2999
J3247	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection secukinumab intravenous 1 mg	8/15/2024	12/31/2999
J3299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection triamcinolone acetonide (xipere) 1 mg	9/15/2022	12/31/2999
J3393	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection betibeglogene autotemcel per treatment	7/1/2024	12/31/2999
J3394	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection lovotibeglogene autotemcel per treatment	7/1/2024	12/31/2999
J3396	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION VERTEPORFIN 0.1 MG	7/15/2007	12/31/2999
J3398	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection voretigene neparvovec-rzyl 1 billion vector genomes	1/1/2019	12/31/2999
J3399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection onasemnogene abeparvovec-xioi per treatment up to 5x10^15 vector genomes	7/1/2020	12/31/2999
J3401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Beremagene geperpavec-svdt for topical administration containing nominal 5 x 10^9 pfu/ml vector genomes per 0.1 ml	2/15/2024	12/31/2999
J3490	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drugs	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3520	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Edetate disodium per 150 mg	1/1/1950	12/31/2999
J3570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laetrile, amygdalin, vitamin b17	6/1/2015	12/31/2999
J3590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified biologics	1/1/1950	12/31/2999
J3591	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drug or biological used for esrd on dialysis	1/1/2019	12/31/2999
J7183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION VON WILLEBRAND FACTOR COMPLEX (HUMAN) WILATE 1 I.U. VWF:RCO	4/1/2024	12/31/2999
J7192	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U., NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J7195	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified	10/24/2019	12/31/2999
J7199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hemophilia clotting factor, not otherwise classified	1/1/1950	12/31/2999
J7311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection fluocinolone acetonide intravitreal implant (retisert) 0.01 mg	6/15/2011	12/31/2999
J7313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection fluocinolone acetonide intravitreal implant (Iluvien) 0.01 mg	1/1/2016	12/31/2999
J7351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection bimatoprost intracameral implant 1 microgram	10/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection travoprost intracameral implant 1 microgram	7/1/2024	12/31/2999
J7599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Immunosuppressive drug, not otherwise classified	1/1/1950	12/31/2999
J7699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, inhalation solution administered through dme	1/1/1950	12/31/2999
J7799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, other than inhalation drugs, administered through dme	1/1/1950	12/31/2999
J7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compounded drug, not otherwise classified	1/1/2016	12/31/2999
J8498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, RECTAL/SUPPOSITORY, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, non chemotherapeutic, nos	1/1/1950	12/31/2999
J8597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, chemotherapeutic, nos	1/1/1950	12/31/2999
J9020	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, asparaginase, not otherwise specified, 10,000 units	10/24/2019	12/31/2025

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9029	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravesical instillation nadofaragene firadenovec-vncg per therapeutic dose	8/1/2023	12/31/2999
J9037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, belantamab mafodontin-blmf, 0.5 mg	4/1/2024	3/31/2025
J9057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, copanlisib, 1 mg	4/1/2024	12/31/2999
J9285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, olaratumab, 10 mg	9/1/2019	12/31/2999
J9313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	4/1/2024	12/31/2999
J9332	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection efgartigimod alfa-fcab 2mg	7/1/2022	12/31/2999
J9333	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection rozanolixizumab-noli 1 mg	2/15/2024	12/31/2999
J9334	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection efgartigimod alfa 2 mg and hyaluronidase-qvfc	2/15/2024	12/31/2999
J9376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection pozelimab-bbfg 1 mg	4/15/2024	12/31/2999
J9600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION PORFIMER SODIUM 75 MG	2/1/2006	12/31/2999
J9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, antineoplastic drugs	1/1/1950	12/31/2999
K0010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment tremor dampening acceleration control and braking	1/1/1950	12/31/2999
K0014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Other motorized/power wheelchair base	1/1/1950	12/31/2999
K0108	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Wheelchair component or accessory, not otherwise specified	2/9/2017	12/31/2999
K0746	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP HOME MODEL PORTABLE PAD SIZE GREATER THAN 48 SQUARE INCHES	8/1/2011	12/31/2999
K0800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 1 STANDARD PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0801	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 1 HEAVY DUTY PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0802	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 1 VERY HEAVY DUTY PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0806	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 2 STANDARD PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0807	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 2 HEAVY DUTY PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE GROUP 2 VERY HEAVY DUTY PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE NOT OTHERWISE CLASSIFIED	10/1/2006	12/31/2999
K0812	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	2/9/2017	12/31/2999
K0813	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 1 STANDARD PORTABLE SLING/SOLID SEAT AND BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 1 STANDARD PORTABLE CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0815	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 1 STANDARD SLING/SOLID SEAT AND BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 1 STANDARD CAPTAINS CHAIR PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD PORTABLE SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD SEAT ELEVATOR SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0831	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD SEAT ELEVATOR CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD SINGLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 HEAVY DUTY SINGLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 VERY HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 EXTRA HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10/1/2006	12/31/2999
K0841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD MULTIPLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 STANDARD MULTIPLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 2 HEAVY DUTY MULTIPLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 STANDARD SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0849	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 STANDARD CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0850	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 HEAVY DUTY SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0851	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 HEAVY DUTY CAPTAINS CHAIR PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0852	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 VERY HEAVY DUTY SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0853	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 VERY HEAVY DUTY CAPTAINS CHAIR PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0854	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 EXTRA HEAVY DUTY SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10/1/2006	12/31/2999
K0855	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 EXTRA HEAVY DUTY CAPTAINS CHAIR PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	10/1/2006	12/31/2999
K0856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 STANDARD SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0857	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 STANDARD SINGLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 3 HEAVY DUTY SINGLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0871	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 VERY HEAVY DUTY SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 STANDARD SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 STANDARD SINGLE POWER OPTION CAPTAINS CHAIR PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 VERY HEAVY DUTY SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT 451 TO 600 POUNDS	10/1/2006	12/31/2999
K0884	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 STANDARD MULTIPLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999
K0885	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 STANDARD MULTIPLE POWER OPTION CAPTAINS CHAIR WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	10/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 4 HEAVY DUTY MULTIPLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	10/1/2006	12/31/2999
K0890	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 5 PEDIATRIC SINGLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	10/1/2006	12/31/2999
K0891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR GROUP 5 PEDIATRIC MULTIPLE POWER OPTION SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	10/1/2006	12/31/2999
K0898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	10/1/2006	12/31/2999
K0899	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power mobile device; no dme pdac	10/1/2006	12/31/2999
K1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator replacement only	4/1/2022	12/31/2999
L0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Addition to spinal orthosis, not otherwise specified	10/24/2019	12/31/2999
L1499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Spinal orthosis, not otherwise specified	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L1834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis without knee joint rigid custom-fabricated	1/1/1950	12/31/2999
L1840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis derotation medial-lateral anterior cruciate ligament custom fabricated	1/1/1950	12/31/2999
L1844	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	KNEE ORTHOSIS SINGLE UPRIGHT THIGH AND CALF WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC) MEDIAL-LATERAL AND ROTATION CONTROL WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT CUSTOM FABRICATED	1/1/1950	12/31/2999
L1846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	KNEE ORTHOSIS DOUBLE UPRIGHT THIGH AND CALF WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC) MEDIAL-LATERAL AND ROTATION CONTROL WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT CUSTOM FABRICATED	1/1/1950	12/31/2999
L2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity orthoses, not otherwise specified	1/1/1950	12/31/2999
L3040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal, each	1/1/1950	12/31/2999
L3050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, metatarsal, each	1/1/1950	12/31/2999
L3060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	1/1/1950	12/31/2999
L3649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Orthopedic shoe, modification, addition or transfer, not otherwise specified	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper limb orthosis, not otherwise specified	1/1/1950	12/31/2999
L5610	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity endoskeletal system above knee hydracadence system	6/1/2006	12/31/2999
L5611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity endoskeletal system above knee - knee disarticulation 4 bar linkage with friction swing phase control	6/1/2006	12/31/2999
L5613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity endoskeletal system above knee-knee disarticulation 4 bar linkage with hydraulic swing phase control	6/1/2006	12/31/2999
L5614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity exoskeletal system above knee-knee disarticulation 4 bar linkage with pneumatic swing phase control	6/1/2006	12/31/2999
L5615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system 4 bar linkage or multiaxial fluid swing and stance phase control	3/15/2024	12/31/2999
L5616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity endoskeletal system above knee universal multiplex system friction swing phase control	6/1/2006	12/31/2999
L5620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity test socket below knee	6/1/2006	12/31/2999
L5624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity test socket above knee	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee acrylic socket	6/1/2006	12/31/2999
L5631	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity above knee or knee disarticulation acrylic socket	6/1/2006	12/31/2999
L5638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee leather socket	6/1/2006	12/31/2999
L5639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee wood socket	6/1/2006	12/31/2999
L5640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity knee disarticulation leather socket	6/1/2006	12/31/2999
L5642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity above knee leather socket	6/1/2006	12/31/2999
L5644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity above knee wood socket	6/1/2006	12/31/2999
L5645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee flexible inner socket external frame	6/1/2006	12/31/2999
L5646	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee air fluid gel or equal cushion socket	6/1/2006	12/31/2999
L5647	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity below knee suction socket	6/1/2006	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5712	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis friction swing and stance phase control (safety knee)	6/1/2006	12/31/2999
L5714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis variable friction swing phase control	6/1/2006	12/31/2999
L5716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system polycentric mechanical stance phase lock	6/1/2006	12/31/2999
L5718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system polycentric friction swing and stance phase control	6/1/2006	12/31/2999
L5722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis pneumatic swing friction stance phase control	6/1/2006	12/31/2999
L5724	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis fluid swing phase control	6/1/2006	12/31/2999
L5726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis external joints fluid swing phase control	6/1/2006	12/31/2999
L5728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis fluid swing and stance phase control	6/1/2006	12/31/2999
L5780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal knee-shin system single axis pneumatic/hydra pneumatic swing phase control	6/1/2006	12/31/2999
L5785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal system below knee ultra-light material (titanium carbon fiber or equal)	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal system above knee ultra-light material (titanium carbon fiber or equal)	6/1/2006	12/31/2999
L5795	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition exoskeletal system hip disarticulation ultra-light material (titanium carbon fiber or equal)	6/1/2006	12/31/2999
L5810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis manual lock	6/1/2006	12/31/2999
L5811	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis manual lock ultra-light material	6/1/2006	12/31/2999
L5812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis friction swing and stance phase control (safety knee)	6/1/2006	12/31/2999
L5814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system polycentric hydraulic swing phase control mechanical stance phase lock	6/1/2006	12/31/2999
L5816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system polycentric mechanical stance phase lock	6/1/2006	12/31/2999
L5818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system polycentric friction swing and stance phase control	6/1/2006	12/31/2999
L5822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis pneumatic swing friction stance phase control	6/1/2006	12/31/2999
L5824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis fluid swing phase control	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis hydraulic swing phase control with miniature high activity frame	6/1/2006	12/31/2999
L5827	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoskeletal knee-shin system single axis electromechanical swing and stance phase control with or without shock absorption and stance extension damping	4/1/2025	12/31/2999
L5828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis fluid swing and stance phase control	6/1/2006	12/31/2999
L5830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system single axis pneumatic/ swing phase control	6/1/2006	12/31/2999
L5840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee/shin system 4-bar linkage or multiaxial pneumatic swing phase control	6/1/2006	12/31/2999
L5841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal knee-shin system polycentric pneumatic swing and stance phase control	4/1/2024	12/31/2999
L5848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM FLUID STANCE EXTENSION DAMPENING FEATURE WITH OR WITHOUT ADJUSTABILITY	6/1/2006	12/31/2999
L5856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS ENDOSKELETAL KNEE-SHIN SYSTEM MICROPROCESSOR CONTROL FEATURE SWING AND STANCE PHASE INCLUDES ELECTRONIC SENSOR(S) ANY TYPE	5/15/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS ENDOSKELETAL KNEE SHIN SYSTEM MICROPROCESSOR CONTROL FEATURE STANCE PHASE ONLY INCLUDES ELECTRONIC SENSOR(S) ANY TYPE	5/15/2007	12/31/2999
L5859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis endoskeletal knee-shin system powered and programmable flexion/extension assist control includes any type motor(s)	1/1/2013	12/31/2999
L5926	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis endoskeletal knee disarticulation above knee hip disarticulation positional rotation unit any type	3/15/2024	12/31/2999
L5961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION ENDOSKELETAL SYSTEM POLYCENTRIC HIP JOINT PNEUMATIC OR HYDRAULIC CONTROL ROTATION CONTROL WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	9/24/2012	12/31/2999
L5962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal system below knee flexible protective outer surface covering system	6/1/2006	12/31/2999
L5964	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal system above knee flexible protective outer surface covering system	6/1/2006	12/31/2999
L5966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal system hip disarticulation flexible protective outer surface covering system	6/1/2006	12/31/2999
L5968	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower limb prosthesis multiaxial ankle with swing phase active dorsiflexion feature	4/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5969	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition endoskeletal ankle-foot or ankle system power assist includes any type motor(s)	1/1/2014	12/31/2999
L5970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses foot external keel sach foot	6/1/2006	12/31/2999
L5972	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses foot flexible keel	6/1/2006	12/31/2999
L5973	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENDOSKELETAL ANKLE FOOT SYSTEM MICROPROCESSOR CONTROLLED FEATURE DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL INCLUDES POWER SOURCE	11/1/2019	12/31/2999
L5974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses foot single axis ankle/foot	6/1/2006	12/31/2999
L5976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses energy storing foot (seattle carbon copy ii or equal)	6/1/2006	12/31/2999
L5978	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses foot multiaxial ankle/foot	6/1/2006	12/31/2999
L5979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis multi-axial ankle dynamic response foot one piece system	6/1/2006	12/31/2999
L5980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses flex foot system	6/1/2006	12/31/2999
L5981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses flex-walk system or equal	6/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All exoskeletal lower extremity prostheses axial rotation unit	6/1/2006	12/31/2999
L5984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prosthesis axial rotation unit with or without adjustability	6/1/2006	12/31/2999
L5985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prostheses dynamic prosthetic pylon	6/1/2006	12/31/2999
L5986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses multi-axial rotation unit ('mcp' or equal)	6/1/2006	12/31/2999
L5987	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis shank foot system with vertical loading pylon	6/1/2006	12/31/2999
L5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L6026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcarpal/metacarpal or partial hand disarticulation prosthesis external power self-suspended inner socket with removable forearm section electrodes and cables two batteries charger myoelectric control of terminal device excludes terminal device(s)	1/1/2015	12/31/2999
L6611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO UPPER EXTREMITY PROSTHESIS EXTERNAL POWERED ADDITIONAL SWITCH ANY TYPE	4/1/2009	12/31/2999
L6621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	UPPER EXTREMITY PROSTHESIS ADDITION FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition external powered feature myoelectronic control module additional emg inputs pattern-recognition decoding intent movement	4/1/2025	12/31/2999
L6880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTOR(S)	1/1/2012	12/31/2999
L6882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control feature addition to upper limb prosthetic terminal device	4/1/2009	12/31/2999
L6920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wrist disarticulation external power self-suspended inner socket removable forearm shell otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999
L6925	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wrist disarticulation external power self-suspended inner socket removable forearm shell otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999
L6930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Below elbow external power self-suspended inner socket removable forearm shell otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Below elbow external power self-suspended inner socket removable forearm shell otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999
L6940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elbow disarticulation external power molded inner socket removable humeral shell outside locking hinges forearm otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999
L6945	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elbow disarticulation external power molded inner socket removable humeral shell outside locking hinges forearm otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999
L6950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Above elbow external power molded inner socket removable humeral shell internal locking elbow forearm otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999
L6955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Above elbow external power molded inner socket removable humeral shell internal locking elbow forearm otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shoulder disarticulation external power molded inner socket removable shoulder shell shoulder bulkhead humeral section mechanical elbow forearm otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999
L6965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shoulder disarticulation external power molded inner socket removable shoulder shell shoulder bulkhead humeral section mechanical elbow forearm otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999
L6970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interscapular-thoracic external power molded inner socket removable shoulder shell shoulder bulkhead humeral section mechanical elbow forearm otto bock or equal switch cables two batteries and one charger switch control of terminal device	4/1/2009	12/31/2999
L6975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interscapular-thoracic external power molded inner socket removable shoulder shell shoulder bulkhead humeral section mechanical elbow forearm otto bock or equal electrodes cables two batteries and one charger myoelectronic control of terminal device	4/1/2009	12/31/2999
L7007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND SWITCH OR MYOELECTRIC CONTROLLED ADULT	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND SWITCH OR MYOELECTRIC CONTROLLED PEDIATRIC	4/1/2009	12/31/2999
L7009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK SWITCH OR MYOELECTRIC CONTROLLED ADULT	4/1/2009	12/31/2999
L7040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PREHENSILE ACTUATOR SWITCH CONTROLLED	4/1/2009	12/31/2999
L7045	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK SWITCH OR MYOELECTRIC ONTROLLED PEDIATRIC	4/1/2009	12/31/2999
L7170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow hosmer or equal switch controlled	4/1/2009	12/31/2999
L7180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow microprocessor sequential control of elbow and terminal device	4/1/2009	12/31/2999
L7181	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRONIC ELBOW MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	4/1/2009	12/31/2999
L7185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow adolescent variety village or equal switch controlled	4/1/2009	12/31/2999
L7186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow child variety village or equal switch controlled	4/1/2009	12/31/2999
L7190	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow adolescent variety village or equal myoelectronically controlled	4/1/2009	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7191	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow child variety village or equal myoelectronically controlled	4/1/2009	12/31/2999
L7259	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic wrist rotator any type	1/1/2015	12/31/2999
L7360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Six volt battery each	4/1/2009	12/31/2999
L7362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger six volt each	4/1/2009	12/31/2999
L7364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Twelve volt battery each	4/1/2009	12/31/2999
L7366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger twelve volt each	4/1/2009	12/31/2999
L7367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lithium ion battery rechargeable replacement	4/1/2009	12/31/2999
L7368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	LITHIUM ION BATTERY CHARGER REPLACEMENT ONLY	7/15/2007	12/31/2999
L7499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L8039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Breast prosthesis, not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8048	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unspecified maxillofacial prosthesis, by report, provided by a non-physician	1/1/1950	12/31/2999
L8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure for miscellaneous prosthetic services	1/1/1950	12/31/2999
L8604	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTABLE BULKING AGENT DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT URINARY TRACT 1 ML INCLUDES SHIPPING AND NECESSARY SUPPLIES	1/1/2009	12/31/2999
L8606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injectable bulking agent synthetic implant urinary tract 1 ml syringe includes shipping and necessary supplies	5/1/2007	12/31/2999
L8607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injectable bulking agent for vocal cord medialization 0.1 ml includes shipping and necessary supplies	1/1/2016	12/31/2999
L8609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ARTIFICIAL CORNEA	1/1/2015	12/31/2999
L8612	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt	7/1/2014	12/31/2999
L8678	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulator supplies (external) for use with implantable neurostimulator per month	7/15/2023	12/31/2999
L8679	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator any type	1/1/2022	12/31/2999
L8680	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator electrode each	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8681	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR REPLACEMENT ONLY	7/15/2023	12/31/2999
L8682	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator radiofrequency receiver	9/19/2022	12/31/2999
L8683	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	7/15/2023	12/31/2999
L8685	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator single array rechargeable includes extension	1/1/2022	12/31/2999
L8686	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator single array non-rechargeable includes extension	1/1/2022	12/31/2999
L8687	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator dual array rechargeable includes extension	1/1/2022	12/31/2999
L8688	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable neurostimulator pulse generator dual array non-rechargeable includes extension	1/1/2022	12/31/2999
L8689	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR REPLACEMENT ONLY	7/15/2023	12/31/2999
L8694	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Auditory osseointegrated device transducer/actuator replacement only each	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8695	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR REPLACEMENT ONLY	9/19/2022	12/31/2999
L8698	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Miscellaneous component supply or accessory for use with total artificial heart system	1/1/2019	12/31/2999
L8699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic implant, not otherwise specified	1/1/1950	12/31/2999
L8701	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered upper extremity range of motion assist device elbow wrist hand with single or double upright(s) includes microprocessor sensors all components and accessories custom fabricated	1/1/2019	12/31/2999
L8702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered upper extremity range of motion assist device elbow wrist hand finger single or double upright(s) includes microprocessor sensors all components and accessories custom fabricated	1/1/2019	12/31/2999
M0075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cellular therapy	1/1/1950	12/31/2999
M0100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intragastric hypothermia using gastric freezing	1/1/1950	12/31/2999
M0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Iv chelation therapy (chemical endarterectomy)	1/1/1950	12/31/2999
M0301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fabric wrapping of abdominal aneurysm	1/1/1950	12/31/2999
P2029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Congo red, blood	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
P2031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hair analysis (excluding arsenic)	9/24/2012	12/31/2999
P9099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Blood component or product not otherwise classified	1/1/2020	12/31/2999
P9603	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled	1/1/1950	12/31/2999
P9604	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge.	1/1/1950	12/31/2999
Q0035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cardiokymography	1/1/1950	12/31/2999
Q0482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device replacement only	10/1/2005	12/31/2999
Q0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor control cable for use with electric ventricular assist device replacement only	10/1/2005	12/31/2999
Q0487	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device replacement only	10/1/2005	12/31/2999
Q0490	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power source for use with electric ventricular assist device replacement only	10/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power supply cable for use with electric ventricular assist device replacement only	10/1/2005	12/31/2999
Q0494	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device replacement only	10/1/2005	12/31/2999
Q0502	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mobility cart for pneumatic ventricular assist device replacement only	10/1/2005	12/31/2999
Q0504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power adapter for pneumatic ventricular assist device replacement only vehicle type	10/1/2005	12/31/2999
Q0507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0508	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0509	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	4/1/2013	12/31/2999
Q0510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH FOLLOWING transPLANT	1/1/2006	12/31/2999
Q0511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	1/1/2006	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0512	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	1/1/2006	12/31/2999
Q2026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION RADIESSE 0.1 ML	8/15/2013	12/31/2999
Q2028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection sculptra 0.5 mg	1/1/2014	12/31/2999
Q2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Influenza virus vaccine, not otherwise specified	10/24/2019	12/31/2999
Q2041	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axicabtagene ciloleucel up to 200 million autologous anti-cd19 car positive viable t cells including leukapheresis and dose preparation procedures per therapeutic dose	4/1/2018	12/31/2999
Q2042	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tisagenlecleucel up to 600 million car-positive viable t cells including leukapheresis and dose preparation procedures per therapeutic dose	7/1/2011	12/31/2999
Q2049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	4/1/2024	12/31/2999
Q2050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg	10/24/2019	12/31/2999
Q2052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	4/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brexucabtagene autoleucel up to 200 million autologous anti-cd19 car positive viable t cells including leukapheresis and dose preparation procedures per therapeutic dose	4/1/2021	12/31/2999
Q2054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lisocabtagene maraleucel up to 110 million autologous anti-cd19 car-positive viable t cells including leukapheresis and dose preparation procedures per therapeutic dose	10/1/2021	12/31/2999
Q2055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Idecabtagene vicleucel up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells including leukapheresis and dose preparation procedures per therapeutic dose	1/1/2022	12/31/2999
Q2056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ciltacabtagene autoleucel up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells including leukapheresis and dose preparation procedures per therapeutic dose	10/1/2022	12/31/2999
Q4050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Cast supplies, for unlisted types and materials of casts	1/1/1950	12/31/2999
Q4051	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	1/1/1950	12/31/2999
Q4082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	1/1/2007	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	1/1/2007	12/31/2999
Q4100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN SUBSTITUTE NOT OTHERWISE SPECIFIED	11/15/2020	12/31/2999
Q4100	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	1/1/2009	12/31/2025
Q4101	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Apligraf per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oasis wound matrix per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DERMAGRAFT PER SQUARE CENTIMETER	11/15/2020	12/31/2999
Q4107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Graftjacket per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra matrix per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4114	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTEGRA FLOWABLE WOUND MATRIX INJECTABLE 1CC	11/15/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4116	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alloderm per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Theraskin per square centimeter (add-on list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermacell dermacell awm or dermacell awm porous per square centimeter (add-on list separately in addition to primary procedure)	10/15/2021	12/31/2999
Q4128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flex hd or allopatch hd per square centimeter (add-on list separately in addition to primary procedure)	11/15/2020	12/31/2999
Q4132	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix core and grafixpl core per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999
Q4133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix prime grafixpl prime stravix and stravixpl per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999
Q4137	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioexcel amnioexcel plus or biodexcel per square centimeter (add-on list separately in addition to primary procedure)	8/1/2024	12/31/2999
Q4151	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioband or guardian per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999
Q4154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biovance per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Affinity per square centimeter (add-on list separately in addition to primary procedure)	2/1/2022	12/31/2999
Q4168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioband 1 mg	8/15/2021	12/31/2999
Q4186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epifix per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999
Q4187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epicord per square centimeter (add-on list separately in addition to primary procedure)	8/15/2021	12/31/2999
Q4283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biovance tri-layer or biovance 3l per square centimeter (add-on list separately in addition to primary procedure)	8/15/2023	12/31/2999
Q4304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix plus per square centimeter (add-on list separately in addition to primary procedure)	3/15/2024	12/31/2999
Q5009	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)	1/1/2007	12/31/2999
Q5106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection epoetin alfa-epbx biosimilar (retacrit) (for non-esrd use) 1000 units	4/15/2020	12/31/2999
Q5109	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection infliximab-qbtx biosimilar (ixifi) 10 mg	10/1/2020	12/31/2999
Q5133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection tocilizumab-bavi (tofidence) biosimilar 1 mg	8/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q5134	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection natalizumab-sztn (tyruko) biosimilar 1 mg	7/1/2024	12/31/2999
Q5135	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection tocilizumab-aazg (tyenne) biosimilar 1 mg	2/15/2025	12/31/2999
Q5138	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection ustekinumab-auub (wezlana) biosimilar intravenous 1 mg	7/15/2024	12/31/2999
Q9997	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection ustekinumab-ttwe (pyzchiva) intravenous 1 mg	3/1/2025	12/31/2999
Q9998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection ustekinumab-aekn (selarsdi) biosimilar 1 mg	3/1/2025	12/31/2999
S0013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esketamine nasal spray 1 mg	2/1/2021	12/31/2999
S0117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tretinoin, topical, 5 grams	1/1/1950	12/31/2999
S0142	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MG	4/1/2005	12/31/2999
S0197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PRENATAL VITAMINS, 30-DAY SUPPLY	4/1/2005	12/31/2999
S0207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport	1/1/1950	12/31/2999
S0209	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Wheelchair van, mileage, per mile	1/1/2021	12/31/2999
S0215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-emergency transportation; mileage per mile	9/24/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	1/1/1950	12/31/2999
S0590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Integral lens service, miscellaneous services reported separately	1/1/1950	12/31/2999
S0800	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laser in situ keratomileusis (lasik)	11/1/2011	12/31/2999
S0810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Photorefractive keratectomy (prk)	1/1/2021	12/31/2999
S1001	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Deluxe item, patient aware (list in addition to code for basic item)	1/1/1950	12/31/2999
S1002	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Customized item (list in addition to code for basic item)	1/1/1950	12/31/2999
S2102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell tissue transplant from pancreas; allogeneic	11/15/2023	12/31/2999
S2107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adoptive immunotherapy i. E. Development of specific anti-tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	2/1/2025	12/31/2999
S2118	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Metal-on-metal total hip resurfacing including acetabular and femoral components	10/1/2008	12/31/2999
S2140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood harvesting for transplantation allogeneic	2/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2142	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood-derived stem-cell transplantation allogeneic	2/1/2013	12/31/2999
S2150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bone marrow or blood-derived stem cells (peripheral or umbilical) allogeneic or autologous harvesting transplantation and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs supplies hospitalization with outpatient follow-up; medical/surgical diagnostic emergency and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition	1/1/1950	12/31/2999
S2202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Echosclerotherapy	9/24/2012	12/31/2999
S2230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear	1/1/1950	12/31/2025
S2400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion procedure performed in utero	10/1/2023	12/31/2999
S2401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair urinary tract obstruction in the fetus procedure performed in utero	10/1/2023	12/31/2999
S2402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair congenital cystic adenomatoid malformation in the fetus procedure performed in utero	10/1/2023	12/31/2999
S2403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair extralobar pulmonary sequestration in the fetus procedure performed in utero	11/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2404	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair myelomeningocele in the fetus procedure performed in utero	10/1/2023	12/31/2999
S2405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of sacrococcygeal teratoma in the fetus procedure performed in utero	11/1/2012	12/31/2999
S2409	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair congenital malformation of fetus procedure performed in utero not otherwise classified	10/1/2023	12/31/2999
S2409	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	10/24/2019	12/31/2999
S2411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	12/1/2022	12/31/2999
S3600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Stat laboratory request (situations other than s3601)	1/1/1950	12/31/2999
S3601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility	1/1/1950	12/31/2999
S4015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Complete in vitro fertilization cycle, not otherwise specified, case rate	10/24/2019	12/31/2999
S4024	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Air polymer-type a intrauterine foam per study dose	4/1/2025	12/31/2999
S4026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Procurement of donor sperm from sperm bank	1/1/1950	12/31/2999
S4027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage of previously frozen embryos	1/1/1950	12/31/2999
S4030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; initial visit	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S4031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; subsequent visit	1/1/1950	12/31/2999
S4040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Monitoring and storage of cryopreserved embryos, per 30 days	1/1/1950	12/31/2999
S4990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, legend	1/1/1950	12/31/2999
S4991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, non-legend	1/1/1950	12/31/2999
S4995	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Smoking cessation gum	1/1/1950	12/31/2999
S5100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per 15 minutes	1/1/1950	12/31/2999
S5101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per half day	1/1/1950	12/31/2999
S5102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per diem	1/1/1950	12/31/2999
S5105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, center-based; services not included in program fee, per diem	1/1/1950	12/31/2999
S5108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training to home care client, per 15 minutes	1/1/1950	12/31/2999
S5109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training to home care client, per session	1/1/1950	12/31/2999
S5110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, family; per 15 minutes	1/1/1950	12/31/2999
S5111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, family; per session	1/1/1950	12/31/2999
S5115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, non-family; per 15 minutes	1/1/1950	12/31/2999
S5116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home care training, non-family; per session	1/1/1950	12/31/2999
S5120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per 15 minutes	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per diem	1/1/1950	12/31/2999
S5125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Attendant care services; per 15 minutes	1/1/1950	12/31/2999
S5126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Attendant care services; per diem	1/1/1950	12/31/2999
S5130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per 15 minutes	1/1/1950	12/31/2999
S5130	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per 15 minutes	1/1/1950	12/31/2999
S5131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per diem	1/1/1950	12/31/2999
S5131	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per diem	1/1/1950	12/31/2999
S5135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per 15 minutes	1/1/1950	12/31/2999
S5136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per diem	1/1/1950	12/31/2999
S5140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per diem	1/1/1950	12/31/2999
S5141	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per month	1/1/1950	12/31/2999
S5145	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per diem	1/1/1950	12/31/2999
S5146	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per month	1/1/1950	12/31/2999
S5150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unskilled respite care, not hospice; per 15 minutes	1/1/1950	12/31/2999
S5151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unskilled respite care, not hospice; per diem	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; installation and testing	1/1/1950	12/31/2999
S5161	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; service fee, per month (excludes installation and testing)	1/1/1950	12/31/2999
S5162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; purchase only	1/1/1950	12/31/2999
S5165	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home modifications; per service	1/1/1950	12/31/2999
S5170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home delivered meals, including preparation; per meal	1/1/1950	12/31/2999
S5175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laundry service, external, professional; per order	1/1/1950	12/31/2999
S5181	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home health respiratory therapy, nos, per diem	10/24/2019	12/31/2999
S5185	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medication reminder service, non-face-to-face; per month	1/1/1950	12/31/2999
S5199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Personal care item, nos, each	1/1/1950	12/31/2999
S5199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Personal care item, nos, each	1/1/1950	12/31/2999
S5497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S8035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic source imaging	4/1/2009	12/31/2999
S8040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Topographic brain mapping	3/1/2024	12/31/2999
S8189	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Tracheostomy supply, not otherwise classified	1/1/1950	12/31/2999
S8270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enuresis alarm, using auditory buzzer and/or vibration device	7/1/2005	12/31/2999
S8301	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infection control supplies, not otherwise specified	1/1/1950	12/31/2999
S8415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supplies for home delivery of infant	1/1/1950	12/31/2999
S8460	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Camisole, post-mastectomy	1/1/1950	12/31/2999
S8930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	11/1/2019	12/31/2999
S8948	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	9/24/2012	12/31/2999
S9002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intra-vaginal motion sensor system provides biofeedback for pelvic floor muscle rehabilitation device	4/1/2024	12/31/2999
S9055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Procuren or other growth factor preparation to promote wound healing	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Respite care, in the home, per diem	1/1/1950	12/31/2999
S9379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/1950	12/31/2999
S9436	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Childbirth preparation/lamaze classes, non-physician provider, per session	1/1/1950	12/31/2999
S9437	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Childbirth refresher classes, non-physician provider, per session	1/1/1950	12/31/2999
S9438	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cesarean birth classes, non-physician provider, per session	1/1/1950	12/31/2999
S9439	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vbac (vaginal birth after cesarean) classes, non-physician provider, per session	1/1/1950	12/31/2999
S9444	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Parenting classes, non-physician provider, per session	1/1/1950	12/31/2999
S9445	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, individual, per session	1/1/1950	12/31/2999
S9446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, group, per session	1/1/1950	12/31/2999
S9447	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Infant safety (including cpr) classes, non-physician provider, per session	1/1/1950	12/31/2999
S9449	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Weight management classes, non-physician provider, per session	1/1/1950	12/31/2999
S9451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Exercise classes, non-physician provider, per session	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9454	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Stress management classes, non-physician provider, per session	1/1/1950	12/31/2999
S9482	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FAMILY STABILIZATION SERVICES, PER 15 MINUTES	1/1/2005	12/31/2999
S9542	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	10/24/2019	12/31/2999
S9558	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home injectable therapy; growth hormone including administrative services professional pharmacy services care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately) per diem	1/1/1950	12/31/2999
S9810	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	10/24/2019	12/31/2999
S9900	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM	1/1/1950	12/31/2999
S9960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service conventional air services nonemergency transport one way (fixed wing)	1/1/2014	12/31/2999
S9961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service conventional air service nonemergency transport one way (rotary wing)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health club membership, annual	1/1/1950	12/31/2999
S9976	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging, per diem, not otherwise classified	1/1/1950	12/31/2999
S9976	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lodging, per diem, not otherwise classified	1/1/1950	12/31/2999
S9977	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals, per diem, not otherwise specified	1/1/1950	12/31/2999
S9977	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Meals, per diem, not otherwise specified	1/1/1950	12/31/2999
S9981	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical records copying fee, administrative	1/1/1950	12/31/2999
S9982	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical records copying fee, per page	1/1/1950	12/31/2999
S9986	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Not medically necessary service (patient is aware that service not medically necessary)	1/1/1950	12/31/2999
S9988	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase i clinical trial	1/1/1950	12/31/2999
S9989	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided outside of the united states of america (list in addition to code(s) for services(s))	1/1/1950	12/31/2999
S9990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase ii clinical trial	1/1/1950	12/31/2999
S9991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services provided as part of a phase iii clinical trial	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9992	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion	1/1/1950	12/31/2999
S9994	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion	1/1/1950	12/31/2999
S9996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals for clinical trial participant and one caregiver/companion	1/1/1950	12/31/2999
S9999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sales tax	1/1/1950	12/31/2999
'T00002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Description for D9223: deep sedation/general anesthesia each 15 minute increment.	12/2/2008	12/31/2999
T1505	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRONIC MEDICATION COMPLIANCE MANAGEMENT DEVICE, INCLUDES ALL COMPONENTS AND ACCESSORIES, NOT OTHERWISE CLASSIFIED	10/24/2019	12/31/2999
T1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks	10/24/2019	12/31/2999
T2012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational; waiver, per diem	7/1/2008	12/31/2999
T2013	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational, waiver; per hour	7/1/2008	12/31/2999
T2014	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per diem	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per hour	7/1/2008	12/31/2999
T2016	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; per diem	7/1/2008	12/31/2999
T2017	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; 15 minutes	7/1/2008	12/31/2999
T2018	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per diem	7/1/2008	12/31/2999
T2019	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per 15 minutes	7/1/2008	12/31/2999
T2020	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per diem	7/1/2008	12/31/2999
T2021	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per 15 minutes	7/1/2008	12/31/2999
T2024	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service assessment/plan of care development, waiver	7/1/2008	12/31/2999
T2025	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Waiver services; not otherwise specified (nos)	7/1/2008	12/31/2999
T2026	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per diem	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2027	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per 15 minutes	7/1/2008	12/31/2999
T2028	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized supply, not otherwise specified, waiver	7/1/2008	12/31/2999
T2029	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized medical equipment, not otherwise specified, waiver	10/24/2019	12/31/2999
T2030	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living, waiver; per month	7/1/2008	12/31/2999
T2031	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living; waiver, per diem	7/1/2008	12/31/2999
T2032	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per month	7/1/2008	12/31/2999
T2033	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per diem	7/1/2008	12/31/2999
T2034	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Crisis intervention, waiver; per diem	7/1/2008	12/31/2999
T2035	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Utility services to support medical equipment and assistive technology/devices, waiver	7/1/2008	12/31/2999
T2036	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, overnight, waiver; each session	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2037	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, day, waiver; each session	7/1/2008	12/31/2999
T2038	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Community transition, waiver; per service	7/1/2008	12/31/2999
T2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vehicle modifications, waiver; per service	7/1/2008	12/31/2999
T2040	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Financial management, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999
T2041	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supports brokerage, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999
T5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supply, not otherwise specified	7/1/2008	12/31/2999
'TQZ43N	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	test	7/30/2008	12/31/2999
V2025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Deluxe frame	1/1/2021	12/31/2999
V2199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, single vision lens	10/24/2019	12/31/2999
V2219	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bifocal seg width over 28mm	1/1/1950	12/31/2999
V2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Contact lens, other type	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hand held low vision aids and other nonspectacle mounted aids	1/1/1950	12/31/2999
V2610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Single lens spectacle mounted low vision aids	1/1/1950	12/31/2999
V2615	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	1/1/1950	12/31/2999
V2627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Scleral cover shell	5/15/2016	12/31/2999
V2629	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic eye, other type	1/1/1950	12/31/2999
V2702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DELUXE LENS FEATURE	1/1/2021	12/31/2999
V2715	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prism, per lens	1/1/1950	12/31/2999
V2718	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Press-on lens, fresnell prism, per lens	1/1/1950	12/31/2999
V2730	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Special base curve, glass or plastic, per lens	1/1/1950	12/31/2999
V2744	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tint, photochromatic, per lens	1/1/1950	12/31/2999
V2750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anti-reflective coating, per lens	1/1/1950	12/31/2999
V2755	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	U-v lens, per lens	1/1/1950	12/31/2999
V2760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scratch resistant coating, per lens	1/1/1950	12/31/2999
V2770	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Occluder lens, per lens	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	10/15/2008	12/31/2999
V2788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	10/15/2008	12/31/2999
V2799	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vision item or service, miscellaneous	1/1/1950	12/31/2999
V2799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vision item or service, miscellaneous	10/24/2019	12/31/2999
V5090	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dispensing fee, unspecified hearing aid	10/24/2019	12/31/2999
V5095	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Semi-implantable middle ear hearing prosthesis	1/1/1950	12/31/2025
V5267	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	1/1/1950	12/31/2999
V5274	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, not otherwise specified	1/1/1950	12/31/2999
V5287	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, personal fm/dm receiver, not otherwise specified	10/24/2019	12/31/2999
V5298	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid, not otherwise classified	1/1/1950	12/31/2999
V5299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing service, miscellaneous	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V5364	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dysphagia screening	1/1/1950	12/31/2999
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0380	BLS mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0382	Basic Life Support (BLS) routine disposable supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS (Advanced Life Support) ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0390	ALS mileage	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0394	ALS specialized service disposable supplies; IV drug therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0396	ALS specialized service disposable supplies; esophageal intubation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0398	ALS routine disposable supplies	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour increments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0425	Ground mileage, per statute mile	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0426	Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1-Emergency)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura.	1/1/2025	12/31/2999
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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
20985	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computer-assisted surgical navigational procedure for musculoskeletal procedures image-less (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
22526	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; single level	1/1/2023	12/31/2999
22527	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
22586	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis pre-sacral interbody technique including disc space preparation discectomy with posterior instrumentation with image guidance includes bone graft when performed L5-S1 interspace	9/1/2020	12/31/2999
22836	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering including thoracoscopy when performed; up to 7 vertebral segments	5/15/2024	12/31/2999
22837	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering including thoracoscopy when performed; 8 or more vertebral segments	5/15/2024	12/31/2999
22838	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg augmentation division of tether) replacement or removal of thoracic vertebral body tethering including thoracoscopy when performed	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22867	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; single level	1/1/2023	12/31/2999
22868	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; second level (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
22869	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; single level	1/1/2023	12/31/2999
22870	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; second level (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
27278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis sacroiliac joint percutaneous with image guidance including placement of intra-articular implant(s) (eg bone allograft[s] synthetic device[s]) without placement of transfixation device	5/15/2024	12/31/2999
30468	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
30469	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with low energy temperature-controlled (ie radiofrequency) subcutaneous/submucosal remodeling	1/1/2023	12/31/2999
31242	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy surgical; with destruction by radiofrequency ablation posterior nasal nerve	5/15/2024	12/31/2999
31243	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy surgical; with destruction by cryoablation posterior nasal nerve	5/15/2024	12/31/2999
33276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]) including vessel catheterization all imaging guidance and pulse generator initial analysis with diagnostic mode activation when performed	5/15/2024	12/31/2999
33277	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	5/15/2024	12/31/2999
33278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; system including pulse generator and lead(s)	5/15/2024	12/31/2999
33279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; transvenous stimulation or sensing lead(s) only	5/15/2024	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
53855	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of a temporary prostatic urethral stent including urethral measurement	5/15/2024	12/31/2999
53860	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	9/1/2020	12/31/2999
61630	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Balloon angioplasty intracranial (eg atherosclerotic stenosis) percutaneous	12/1/2020	12/31/2999
62263	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline enzyme) or mechanical means (eg catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 2 or more days	8/1/2022	12/31/2999
62264	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline enzyme) or mechanical means (eg catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 1 day	8/1/2022	12/31/2999
62287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Decompression procedure percutaneous of nucleus pulposus of intervertebral disc any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization with discography and/or epidural injection(s) at the treated level(s) when performed single or multiple levels lumbar	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64628	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Thermal destruction of intraosseous basivertebral nerve including all imaging guidance; first 2 vertebral bodies lumbar or sacral	8/1/2022	12/31/2999
64629	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Thermal destruction of intraosseous basivertebral nerve including all imaging guidance; each additional vertebral body lumbar or sacral (List separately in addition to code for primary procedure)	8/1/2022	12/31/2999
83987	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	pH; exhaled breath condensate	12/1/2020	12/31/2999
88375	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical endomicroscopic image(s) interpretation and report real-time or referred each endoscopic session	9/1/2020	12/31/2999
91113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal tract imaging intraluminal (eg capsule endoscopy) colon with interpretation and report	1/1/2023	12/31/2999
93150	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Therapy activation of implanted phrenic nerve stimulator system including all interrogation and programming	5/15/2024	12/31/2999
93151	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999
93152	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	5/15/2024	12/31/2999
93153	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation without programming of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94014	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education transmission of spirometric tracing data capture analysis of transmitted data periodic recalibration and review and interpretation by a physician or other qualified health care professional	9/1/2020	12/31/2999
94015	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up reinforced education data transmission data capture trend analysis and periodic recalibration)	9/1/2020	12/31/2999
94016	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	9/1/2020	12/31/2999
95919	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative pupillometry with physician or other qualified health care professional interpretation and report unilateral or bilateral	1/1/2023	12/31/2999
0054T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computer-assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0055T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computer-assisted musculoskeletal surgical navigational orthopedic procedure with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0062U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autoimmune (systemic lupus erythematosus) IgG and IgM analysis of 80 biomarkers utilizing serum algorithm reported with a risk score	12/1/2020	12/31/2999
0075T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter placement of extracranial vertebral artery stent(s) including radiologic supervision and interpretation open or percutaneous; initial vessel	1/1/2026	12/31/2999
0076T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter placement of extracranial vertebral artery stent(s) including radiologic supervision and interpretation open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0100T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a subconjunctival retinal prosthesis receiver and pulse generator and implantation of intraocular retinal electrode array with vitrectomy	1/1/2026	12/31/2999
0200T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous sacral augmentation (sacroplasty) unilateral injection(s) including the use of a balloon or mechanical device when used 1 or more needles includes imaging guidance and bone biopsy when performed	1/1/2026	12/31/2999
0201T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous sacral augmentation (sacroplasty) bilateral injections including the use of a balloon or mechanical device when used 2 or more needles includes imaging guidance and bone biopsy when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0202T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Posterior vertebral joint(s) arthroplasty (eg facet joint[s] replacement) including facetectomy laminectomy foraminotomy and vertebral column fixation injection of bone cement when performed including fluoroscopy single level lumbar spine	12/1/2020	12/31/2999
0208T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold) automated; air only	1/1/2026	12/31/2999
0209T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold) automated; air and bone	1/1/2026	12/31/2999
0210T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold automated;	1/1/2026	12/31/2999
0211T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold automated; with speech recognition	1/1/2026	12/31/2999
0212T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive audiometry threshold evaluation and speech recognition (0209T 0211T combined) automated	1/1/2026	12/31/2999
0219T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s) unilateral or bilateral including imaging and placement of bone graft(s) or synthetic device(s) single level; cervical	12/1/2020	12/31/2999
0220T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s) unilateral or bilateral including imaging and placement of bone graft(s) or synthetic device(s) single level; thoracic	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0221T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s) unilateral or bilateral including imaging and placement of bone graft(s) or synthetic device(s) single level; lumbar	12/1/2020	12/31/2999
0222T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s) unilateral or bilateral including imaging and placement of bone graft(s) or synthetic device(s) single level; each additional vertebral segment (List separately in addition to code for primary procedure)	12/1/2020	12/31/2999
0232T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s) platelet rich plasma any site including image guidance harvesting and preparation when performed	12/1/2020	12/31/2999
0234T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy open or percutaneous including radiological supervision and interpretation; renal artery	1/1/2026	12/31/2999
0235T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy open or percutaneous including radiological supervision and interpretation; visceral artery (except renal) each vessel	1/1/2026	12/31/2999
0236T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy open or percutaneous including radiological supervision and interpretation; abdominal aorta	1/1/2026	12/31/2999
0237T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy open or percutaneous including radiological supervision and interpretation; brachiocephalic trunk and branches each vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0263T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy with preparation of harvested cells multiple injections one leg including ultrasound guidance if performed; complete procedure including unilateral or bilateral bone marrow harvest	9/1/2020	12/31/2999
0264T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy with preparation of harvested cells multiple injections one leg including ultrasound guidance if performed; complete procedure excluding bone marrow harvest	9/1/2020	12/31/2999
0265T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy with preparation of harvested cells multiple injections one leg including ultrasound guidance if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	9/1/2020	12/31/2999
0274T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection discectomy facetectomy and/or foraminotomy) any method under indirect image guidance (eg fluoroscopic CT) single or multiple levels unilateral or bilateral; cervical or thoracic	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0275T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection discectomy facetectomy and/or foraminotomy) any method under indirect image guidance (eg fluoroscopic CT) single or multiple levels unilateral or bilateral; lumbar	1/1/2023	12/31/2999
0322U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neurology (autism spectrum disorder [ASD]) quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites liquid chromatography with tandem mass spectrometry (LC-MS/MS) plasma results reported as negative or positive for risk of metabolic subtypes associated with ASD	1/15/2024	12/31/2999
0335T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of sinus tarsi implant	12/1/2020	12/31/2999
0338T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter 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	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0339T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter 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	9/1/2020	12/31/2999
0351T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node excised tissue each specimen; real-time intraoperative	1/1/2026	12/31/2999
0352T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node excised tissue each specimen; interpretation and report real-time or referred	1/1/2026	12/31/2999
0353T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast surgical cavity; real-time intraoperative	1/1/2026	12/31/2999
0354T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast surgical cavity; interpretation and report real-time or referred	1/1/2026	12/31/2999
0369U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0397T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic retrograde cholangiopancreatography (ERCP) with optical endomicroscopy (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0422T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tactile breast imaging by computer-aided tactile sensors unilateral or bilateral	1/1/2026	12/31/2999
0437T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of non-biologic or synthetic implant (eg polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0439T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial contrast perfusion echocardiography at rest or with stress for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0440T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation percutaneous cryoablation includes imaging guidance; upper extremity distal/peripheral nerve	1/1/2026	12/31/2999
0441T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation percutaneous cryoablation includes imaging guidance; lower extremity distal/peripheral nerve	1/1/2026	12/31/2999
0442T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation percutaneous cryoablation includes imaging guidance; nerve plexus or other truncal nerve (eg brachial plexus pudendal nerve)	1/1/2026	12/31/2999
0444T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initial placement of a drug-eluting ocular insert under one or more eyelids including fitting training and insertion unilateral or bilateral	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0445T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Subsequent placement of a drug-eluting ocular insert under one or more eyelids including re-training and removal of existing insert unilateral or bilateral	1/1/2026	12/31/2999
0469T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Retinal polarization scan ocular screening with on-site automated results bilateral	1/1/2026	12/31/2999
0472T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation interrogation and initial programming of intraocular retinal electrode array (eg retinal prosthesis) in person with iterative adjustment of the implantable device to test functionality select optimal permanent programmed values with analysis including visual training with review and report by a qualified health care professional	1/1/2026	12/31/2999
0473T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation and interrogation of intraocular retinal electrode array (eg retinal prosthesis) in person including reprogramming and visual training when performed with review and report by a qualified health care professional	1/1/2026	12/31/2999
0494T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system including decannulation separation from the perfusion system and cold preservation of the allograft prior to implantation when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0495T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional including physiological and laboratory assessment (eg pulmonary artery flow pulmonary artery pressure left atrial pressure pulmonary vascular resistance mean/peak and plateau airway pressure dynamic compliance and perfusate gas analysis) including bronchoscopy and X ray when performed; first two hours in sterile field	1/1/2026	12/31/2999
0496T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional including physiological and laboratory assessment (eg pulmonary artery flow pulmonary artery pressure left atrial pressure pulmonary vascular resistance mean/peak and plateau airway pressure dynamic compliance and perfusate gas analysis) including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0506T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Macular pigment optical density measurement by heterochromatic flicker photometry unilateral or bilateral with interpretation and report	1/1/2026	12/31/2999

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0511T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and reinsertion of sinus tarsi implant	12/1/2020	12/31/2999
0524T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein open or percutaneous including all vascular access catheter manipulation diagnostic imaging imaging guidance and monitoring	1/1/2026	12/31/2999
0541T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia by signal acquisition using minimum 36 channel grid generation of magnetic-field time-series images quantitative analysis of magnetic dipoles machine learning-derived clinical scoring and automated report generation single study;	1/1/2026	12/31/2999
0542T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia by signal acquisition using minimum 36 channel grid generation of magnetic-field time-series images quantitative analysis of magnetic dipoles machine learning-derived clinical scoring and automated report generation single study; interpretation and report	1/1/2026	12/31/2999
0543T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transapical mitral valve repair including transthoracic echocardiography when performed with placement of artificial chordae tendineae	1/1/2026	12/31/2999

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0545T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device percutaneous approach	1/1/2026	12/31/2999
0546T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiofrequency spectroscopy real time intraoperative margin assessment at the time of partial mastectomy with report	1/1/2026	12/31/2999
0547T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone-material quality testing by microindentation(s) of the tibia(s) with results reported as a score	1/1/2026	12/31/2999
0554T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data assessment of bone strength and fracture risk and bone-mineral density interpretation and report	1/1/2026	12/31/2999
0555T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data	1/1/2026	12/31/2999
0556T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0557T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; interpretation and report	1/1/2026	12/31/2999
0558T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	1/1/2026	12/31/2999
0565T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	8/15/2021	12/31/2999
0566T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance unilateral	8/15/2021	12/31/2999
0582T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy including intraoperative imaging and needle guidance	1/1/2026	12/31/2999
0591T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; individual initial assessment	1/1/2026	12/31/2999
0592T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; individual follow-up session at least 30 minutes	1/1/2026	12/31/2999
0593T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Health and well-being coaching face-to-face; group (2 or more individuals) at least 30 minutes	1/1/2026	12/31/2999

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0594T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Osteotomy humerus with insertion of an externally controlled intramedullary lengthening device including intraoperative imaging initial and subsequent alignment assessments computations of adjustment schedules and management of the intramedullary lengthening device	1/1/2026	12/31/2999
0598T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact real-time fluorescence wound imaging for bacterial presence location and load per session; first anatomic site (eg lower extremity)	10/1/2024	12/31/2999
0599T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	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)	10/1/2024	12/31/2999
0602T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) measurement(s) transdermal including sensor placement and administration of a single dose of fluorescent pyrazine agent	4/1/2021	12/31/2999
0603T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) monitoring transdermal including sensor placement and administration of more than one dose of fluorescent pyrazine agent each 24 hours	4/1/2021	12/31/2999

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0604T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina remote patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision set-up and patient education on use of equipment	1/1/2026	12/31/2999
0605T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina remote patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support data analyses and reports with a minimum of 8 daily recordings each 30 days	1/1/2026	12/31/2999
0606T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina remote patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; review interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses each 30 days	1/1/2026	12/31/2999
0607T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system including measurement of radiofrequency-derived pulmonary fluid levels heart rate respiration rate activity posture and cardiovascular rhythm (eg ECG data) transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0608T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system including measurement of radiofrequency-derived pulmonary fluid levels heart rate respiration rate activity posture and cardiovascular rhythm (eg ECG data) transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	1/1/2026	12/31/2999
0609T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy determination and localization of discogenic pain (cervical thoracic or lumbar); acquisition of single voxel data per disc on biomarkers (ie lactic acid carbohydrate alanine laal propionic acid proteoglycan and collagen) in at least 3 discs	1/1/2026	12/31/2999
0610T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy determination and localization of discogenic pain (cervical thoracic or lumbar); transmission of biomarker data for software analysis	1/1/2026	12/31/2999
0611T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy determination and localization of discogenic pain (cervical thoracic or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0612T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy determination and localization of discogenic pain (cervical thoracic or lumbar); interpretation and report	1/1/2026	12/31/2999
0613T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter implantation of interatrial septal shunt device including right and left heart catheterization intracardiac echocardiography and imaging guidance by the proceduralist when performed	1/1/2026	12/31/2999
0615T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of binocular eye movements without spatial calibration including disconjugacy saccades and pupillary dynamics for the assessment of concussion with interpretation and report	5/15/2021	12/31/2999
0619T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery including transrectal ultrasound and fluoroscopy when performed	7/1/2024	12/31/2999
0620T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular venous arterialization tibial or peroneal vein with transcatheter placement of intravascular stent graft(s) and closure by any method including percutaneous or open vascular access ultrasound guidance for vascular access when performed all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention all associated radiological supervision and interpretation when performed	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0621T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser;	1/1/2021	12/31/2999
0622T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	1/1/2021	12/31/2999
0623T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease using data from coronary computed tomographic angiography; data preparation and transmission computerized analysis of data with review of computerized analysis output to reconcile discordant data interpretation and report	1/1/2021	12/31/2999
0624T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease using data from coronary computed tomographic angiography; data preparation and transmission	1/1/2021	12/31/2999
0625T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0626T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data interpretation and report	1/1/2021	12/31/2999
0627T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product intervertebral disc unilateral or bilateral injection with fluoroscopic guidance lumbar; first level	1/1/2021	12/31/2999
0628T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product intervertebral disc unilateral or bilateral injection with fluoroscopic guidance lumbar; each additional level (List separately in addition to code for primary procedure)	1/1/2021	12/31/2999
0629T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product intervertebral disc unilateral or bilateral injection with CT guidance lumbar; first level	1/1/2021	12/31/2999
0630T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product intervertebral disc unilateral or bilateral injection with CT guidance lumbar; each additional level (List separately in addition to code for primary procedure)	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0631T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin deoxyhemoglobin and tissue oxygenation with interpretation and report per extremity	1/1/2021	12/31/2999
0632T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries including right heart catheterization pulmonary artery angiography and all imaging guidance	1/1/2026	12/31/2999
0639T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt including ultrasound guidance when performed	1/1/2021	12/31/2999
0640T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation) other than for screening for peripheral arterial disease image acquisition interpretation and report; first anatomic site	7/1/2021	12/31/2999
0643T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed arterial approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0644T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter removal or debulking of intracardiac mass (eg vegetations thrombus) via suction (eg vacuum aspiration) device percutaneous approach with intraoperative reinfusion of aspirated blood including imaging guidance when performed	1/1/2026	12/31/2999
0645T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of coronary sinus reduction device including vascular access and closure right heart catheterization venous angiography coronary sinus angiography imaging guidance and supervision and interpretation when performed	1/1/2026	12/31/2999
0647T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of gastrostomy tube percutaneous with magnetic gastropexy under ultrasound guidance image documentation and report	1/1/2026	12/31/2999
0651T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetically controlled capsule endoscopy esophagus through stomach including intraprocedural positioning of capsule with interpretation and report	1/1/2023	12/31/2999
0652T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy flexible transnasal; diagnostic including collection of specimen(s) by brushing or washing when performed (separate procedure)	1/1/2026	12/31/2999
0653T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy flexible transnasal; with biopsy single or multiple	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0654T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy flexible transnasal; with insertion of intraluminal tube or catheter	1/1/2026	12/31/2999
0656T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	7/1/2021	12/31/2999
0657T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	7/1/2021	12/31/2999
0658T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	1/1/2026	12/31/2999
0659T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction including catheter placement imaging guidance (eg fluoroscopy) angiography and radiologic supervision and interpretation	1/1/2026	12/31/2999
0664T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open from cadaver donor	8/15/2021	12/31/2999
0665T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open from living donor	8/15/2021	12/31/2999
0666T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); laparoscopic or robotic from living donor	8/15/2021	12/31/2999

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0667T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	8/15/2021	12/31/2999
0668T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies) as necessary	8/15/2021	12/31/2999
0669T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis each	8/15/2021	12/31/2999
0670T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis each	8/15/2021	12/31/2999
0672T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovaginal cryogen-cooled monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	1/1/2023	12/31/2999
0673T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation benign thyroid nodule(s) percutaneous laser including imaging guidance	1/1/2026	12/31/2999
0674T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function including an implantable pulse generator and diaphragmatic lead(s)	1/1/2026	12/31/2999

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0675T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s) permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function including connection to an existing pulse generator; first lead	1/1/2026	12/31/2999
0676T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s) permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0677T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s) permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function including connection to an existing pulse generator; first repositioned lead	1/1/2026	12/31/2999
0678T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s) permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0679T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic removal of diaphragmatic lead(s) permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0680T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of pulse generator only permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function with connection to existing lead(s)	1/1/2026	12/31/2999
0681T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Relocation of pulse generator only permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function with connection to existing dual leads	1/1/2026	12/31/2999
0682T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of pulse generator only permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0683T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis review and report by a physician or other qualified health care professional permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999

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0684T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery procedure or test with analysis review and report by a physician or other qualified health care professional permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0685T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation device evaluation (in-person) with analysis review and report by a physician or other qualified health care professional including connection recording and disconnection per patient encounter permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0686T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue including image guidance	1/1/2026	12/31/2999
0687T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; device supply educational set-up and initial session	1/1/2026	12/31/2999
0688T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional with report per calendar month	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0689T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic) including interpretation and report obtained without diagnostic ultrasound examination of the same anatomy (eg organ gland tissue target structure)	1/1/2026	12/31/2999
0690T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic) including interpretation and report obtained with diagnostic ultrasound examination of the same anatomy (eg organ gland tissue target structure) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0691T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of an existing computed tomography study for vertebral fracture(s) including assessment of bone density when performed data preparation interpretation and report	1/1/2026	12/31/2999
0693T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	1/1/2026	12/31/2999
0694T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue each excised specimen 3-dimensional automatic specimen reorientation interpretation and report real-time intraoperative	1/1/2026	12/31/2999

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0695T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony cardiac resynchronization therapy device including connection recording disconnection review and report; at time of implant or replacement	1/1/2026	12/31/2999
0696T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony cardiac resynchronization therapy device including connection recording disconnection review and report; at time of follow-up interrogation or programming device evaluation	1/1/2026	12/31/2999
0697T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg fat iron water content) including multiparametric data acquisition data preparation and transmission interpretation and report obtained without diagnostic MRI examination of the same anatomy (eg organ gland tissue target structure) during the same session; multiple organs	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0698T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg fat iron water content) including multiparametric data acquisition data preparation and transmission interpretation and report obtained with diagnostic MRI examination of the same anatomy (eg organ gland tissue target structure); multiple organs (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0699T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection posterior chamber of eye medication	1/1/2026	12/31/2999
0700T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; first lesion	1/1/2026	12/31/2999
0701T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0704T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0705T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis with a minimum of 18 training hours each 30 days	1/1/2026	12/31/2999

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0706T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional per calendar month	1/1/2026	12/31/2999
0708T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intradermal cancer immunotherapy; preparation and initial injection	1/1/2026	12/31/2999
0709T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0714T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transperineal laser ablation of benign prostatic hyperplasia including imaging guidance; prostate volume less than 50 mL	1/1/2026	12/31/2999
0716T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score	1/1/2026	12/31/2999
0717T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting isolation and preparation of harvested cells including incubation with cell dissociation enzymes filtration washing and concentration of ADRCs	1/1/2026	12/31/2999
0718T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance unilateral	1/1/2026	12/31/2999

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0719T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Posterior vertebral joint replacement including bilateral facetectomy laminectomy and radical discectomy including imaging guidance lumbar spine single segment	1/1/2026	12/31/2999
0721T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative computed tomography (CT) tissue characterization including interpretation and report obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999
0722T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative computed tomography (CT) tissue characterization including interpretation and report obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0723T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission interpretation and report obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg organ gland tissue target structure) during the same session	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0724T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission interpretation and report obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg organ gland tissue target structure) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0725T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular device implantation unilateral	1/1/2026	12/31/2999
0726T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of implanted vestibular device unilateral	1/1/2026	12/31/2999
0727T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and replacement of implanted vestibular device unilateral	1/1/2026	12/31/2999
0728T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Diagnostic analysis of vestibular implant unilateral; with initial programming	1/1/2026	12/31/2999
0729T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Diagnostic analysis of vestibular implant unilateral; with subsequent programming	1/1/2026	12/31/2999
0730T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculotomy by laser including optical coherence tomography (OCT) guidance	1/1/2026	12/31/2999
0731T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative AI-based facial phenotype analysis with report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0732T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Immunotherapy administration with electroporation intramuscular	1/1/2026	12/31/2999
0733T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote real-time motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support per 30 days	1/1/2026	12/31/2999
0734T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote real-time motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional per calendar month	1/1/2026	12/31/2999
0735T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Preparation of tumor cavity with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0736T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonic lavage 35 or more liters of water gravity-fed with induced defecation including insertion of rectal catheter	1/1/2026	12/31/2999
0737T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xenograft implantation into the articular surface	1/1/2026	12/31/2999
0738T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment planning for magnetic field induction ablation of malignant prostate tissue using data from previously performed magnetic resonance imaging (MRI) examination	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0739T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation of malignant prostate tissue by magnetic field induction including all intraprocedural transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring thermal dosimetry bladder irrigation and magnetic field nanoparticle activation	1/1/2026	12/31/2999
0742T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Absolute quantitation of myocardial blood flow (AQMBF) single-photon emission computed tomography (SPECT) with exercise or pharmacologic stress and at rest when performed (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0743T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD) with concurrent vertebral fracture assessment utilizing data from a computed tomography scan retrieval and transmission of the scan data measurement of bone strength and BMD and classification of any vertebral fractures with overall fracture-risk assessment interpretation and report	1/1/2023	12/31/2999
0744T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of bioprosthetic valve open femoral vein including duplex ultrasound imaging guidance when performed including autogenous or nonautogenous patch graft (eg polyester ePTFE bovine pericardium) when performed	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0745T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus) derived from anatomical image data (eg CT MRI or myocardial perfusion scan) and electrical data (eg 12-lead ECG data) and identification of areas of avoidance	1/1/2026	12/31/2999
0746T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	1/1/2026	12/31/2999
0747T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy arrhythmia	1/1/2026	12/31/2999
0748T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injections of stem cell product into perianal perifistular soft tissue including fistula preparation (eg removal of setons fistula curettage closure of internal openings)	9/1/2023	12/31/2999
0749T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray retrieval and transmission of digital X-ray data assessment of bone strength and fracture risk and BMD interpretation and report;	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0750T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray retrieval and transmission of digital X-ray data assessment of bone strength and fracture risk and BMD interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	1/1/2026	12/31/2999
0751T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level II surgical pathology gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0752T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level III surgical pathology gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0753T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level IV surgical pathology gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0754T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level V surgical pathology gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0755T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level VI surgical pathology gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0756T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain including interpretation and report group I for microorganisms (eg acid fast methenamine silver) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0757T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain including interpretation and report group II all other (eg iron trichrome) except stain for microorganisms stains for enzyme constituents or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0758T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain including interpretation and report histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0759T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain including interpretation and report group III for enzyme constituents (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0760T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry per specimen initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0761T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry per specimen each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0762T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry per specimen each multiplex antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0763T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis tumor immunohistochemistry (eg Her-2/neu estrogen receptor/progesterone receptor) quantitative or semiquantitative per specimen each single antibody stain procedure manual (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0764T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg low-ejection fraction pulmonary hypertension hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0765T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg low-ejection fraction pulmonary hypertension hypertrophic cardiomyopathy); related to previously performed electrocardiogram	1/1/2026	12/31/2999
0766T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse peripheral nerve with identification and marking of the treatment location including noninvasive electroneurographic localization (nerve conduction localization) when performed; first nerve	7/1/2023	12/31/2999
0767T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse peripheral nerve with identification and marking of the treatment location including noninvasive electroneurographic localization (nerve conduction localization) when performed; each additional nerve (List separately in addition to code for primary procedure)	7/1/2023	12/31/2999
0770T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0771T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports requiring the presence of an indeBIT 429 Reviewent trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time patient age 5 years or older	9/1/2023	12/31/2999
0772T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports requiring the presence of an indeBIT 429 Reviewent trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0773T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time patient age 5 years or older	9/1/2023	12/31/2999
0774T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	9/1/2023	12/31/2999
0776T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Therapeutic induction of intra-brain hypothermia including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head including monitoring (eg vital signs and sport concussion assessment tool 5 [SCAT5]) 30 minutes of treatment	9/1/2023	12/31/2999
0777T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0778T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion posture gait and muscle function	9/1/2023	12/31/2999
0779T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal myoelectrical activity study stomach through colon with interpretation and report	9/1/2023	12/31/2999
0781T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy rigid or flexible with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves including fluoroscopic guidance when performed; bilateral mainstem bronchi	9/1/2023	12/31/2999
0782T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy rigid or flexible with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves including fluoroscopic guidance when performed; unilateral mainstem bronchus	9/1/2023	12/31/2999
0783T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous auricular neurostimulation set-up calibration and patient education on use of equipment	1/1/2023	12/31/2999
0790T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg augmentation division of tether) replacement or removal of thoracolumbar or lumbar vertebral body tethering including thoracoscopy when performed	5/15/2024	12/31/2999
0791T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motor-cognitive semi-immersive virtual reality-facilitated gait training each 15 minutes (List separately in addition to code for primary procedure)	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0792T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Application of silver diamine fluoride 38% by a physician or other qualified health care professional	1/1/2026	12/31/2999
0793T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries including right heart catheterization pulmonary artery angiography and all imaging guidance	1/1/2026	12/31/2999
0794T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-specific assistive rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology immunohistochemical or other pathology results which have been previously interpreted and reported separately	1/1/2026	12/31/2999
0805T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie caval valve implantation [CAVI]); percutaneous femoral vein approach	1/1/2026	12/31/2999
0806T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie caval valve implantation [CAVI]); open femoral vein approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0807T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images including data preparation and transmission quantification of pulmonary tissue ventilation data review interpretation and report	7/1/2023	12/31/2999
0808T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis including data preparation and transmission quantification of pulmonary tissue ventilation data review interpretation and report	7/1/2023	12/31/2999
0811T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote multi-day complex uroflowmetry (eg calibrated electronic equipment); set-up and patient education on use of equipment	1/1/2026	12/31/2999
0812T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote multi-day complex uroflowmetry (eg calibrated electronic equipment); device supply with automated report generation up to 10 days	1/1/2026	12/31/2999
0813T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy flexible transoral with volume adjustment of intragastric bariatric balloon	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0814T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of calcium-based biodegradable osteoconductive material proximal femur including imaging guidance unilateral	1/1/2026	12/31/2999
0815T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS) bone-density study and fracture-risk assessment 1 or more sites hips pelvis or spine	1/1/2026	12/31/2999
0816T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg array or leadless) and pulse generator or receiver including analysis programming and imaging guidance when performed posterior tibial nerve; subcutaneous	7/1/2024	12/31/2999
0818T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction including analysis programming and imaging when performed posterior tibial nerve; subcutaneous	7/1/2024	12/31/2999
0819T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction including analysis programming and imaging when performed posterior tibial nerve; subfascial	1/1/2026	12/31/2999

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0820T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg psychotherapy crisis intervention) as needed during psychedelic medication therapy; first physician or other qualified health care professional each hour	1/1/2026	12/31/2999
0821T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg psychotherapy crisis intervention) as needed during psychedelic medication therapy; second physician or other qualified health care professional concurrent with first physician or other qualified health care professional each hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0822T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg psychotherapy crisis intervention) as needed during psychedelic medication therapy; clinical staff under the direction of a physician or other qualified health care professional concurrent with first physician or other qualified health care professional each hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0827T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology fluids washings or brushings except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0828T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology fluids washings or brushings except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0829T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology concentration technique smears and interpretation (eg Saccomanno technique) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0830T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology selective-cellular enhancement technique with interpretation (eg liquid-based slide preparation method) except cervical or vaginal (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0831T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology cervical or vaginal (any reporting system) requiring interpretation by physician (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0832T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology smears any other source; screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0833T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology smears any other source; preparation screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0834T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology smears any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0835T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis first evaluation episode each site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0837T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0838T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0839T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0840T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation comprehensive with review of records and specimens with report on referred material (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0841T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block with frozen section(s) single specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0842T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0843T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg touch preparation squash preparation) initial site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0844T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg touch preparation squash preparation) each additional site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0845T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0846T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0847T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for examination and selection of retrieved archival (ie previously diagnosed) tissue(s) for molecular analysis (eg KRAS mutational analysis) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0848T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg FISH) per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0849T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg FISH) per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0850T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg FISH) per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0851T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis in situ hybridization (quantitative or semiquantitative) manual per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0852T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis in situ hybridization (quantitative or semiquantitative) manual per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0853T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis in situ hybridization (quantitative or semiquantitative) manual per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0854T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for blood smear peripheral interpretation by physician with written report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0855T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for bone marrow smear interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0856T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for electron microscopy diagnostic (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0857T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Opto-acoustic imaging breast unilateral including axilla when performed real-time with image documentation augmentative analysis and report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0858T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	10/1/2024	12/31/2999
0859T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation) other than for screening for peripheral arterial disease image acquisition interpretation and report; each additional anatomic site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0860T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg for measurement of deoxyhemoglobin oxyhemoglobin and ratio of tissue oxygenation) for screening for peripheral arterial disease including provocative maneuvers image acquisition interpretation and report one or both lower extremities	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0864T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum low energy	7/1/2024	12/31/2999
0865T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies) including lesion identification characterization and quantification with brain volume(s) quantification and/or severity score when performed data preparation and transmission interpretation and report obtained without diagnostic MRI examination of the brain during the same session	1/1/2026	12/31/2999
0866T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies) including lesion detection characterization and quantification with brain volume(s) quantification and/or severity score when performed data preparation and transmission interpretation and report obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0867T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transperineal laser ablation of benign prostatic hyperplasia including imaging guidance; prostate volume greater or equal to 50 mL	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0868T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, with interpretation and report	6/15/2025	12/31/2999
0869T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s) bone-substitute material for bone and/or soft tissue hardware fixation augmentation including intraoperative imaging guidance when performed	1/1/2026	12/31/2999
0870T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of subcutaneous peritoneal ascites pump system percutaneous including pump-pocket creation insertion of tunneled indwelling bladder and peritoneal catheters with pump connections including all imaging and initial programming when performed	5/15/2025	12/31/2999
0871T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of a subcutaneous peritoneal ascites pump including reconnection between pump and indwelling bladder and peritoneal catheters including initial programming and imaging when performed	5/15/2025	12/31/2999
0872T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of indwelling bladder and peritoneal catheters including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump including imaging and programming when performed	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0873T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision of a subcutaneously implanted peritoneal ascites pump system any component (ascites pump associated peritoneal catheter associated bladder catheter) including imaging and programming when performed	5/15/2025	12/31/2999
0874T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of a peritoneal ascites pump system including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	5/15/2025	12/31/2999
0875T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	5/15/2025	12/31/2999
0876T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Duplex scan of hemodialysis fistula computer-aided limited (volume flow diameter and depth including only body of fistula)	1/1/2026	12/31/2999
0877T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999
0878T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0879T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission	1/1/2026	12/31/2999
0880T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
0881T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cryotherapy of the oral cavity using temperature regulated fluid cooling system including placement of an oral device monitoring of patient tolerance to treatment and removal of the oral device	1/1/2026	12/31/2999
0882T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration including lead placement and removal upper extremity minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0883T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration including lead placement and removal upper extremity minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0884T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagoscopy flexible transoral with initial transendoscopic mechanical dilation (eg nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture including fluoroscopic guidance when performed	1/1/2026	12/31/2999
0885T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonoscopy flexible with initial transendoscopic mechanical dilation (eg nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture including fluoroscopic guidance when performed	1/1/2026	12/31/2999
0886T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sigmoidoscopy flexible with initial transendoscopic mechanical dilation (eg nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture including fluoroscopic guidance when performed	1/1/2026	12/31/2999
0887T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0888T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie non-thermal ablation via acoustic energy delivery) of malignant renal tissue including imaging guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0893T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of blood oxygenation gas exchange efficiency and cardiorespiratory status with physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
0897T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters including uploading clinical parameters with interpretation and report	1/1/2026	12/31/2999
0898T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive prostate cancer estimation map derived from augmentative analysis of image-guided fusion biopsy and pathology including visualization of margin volume and location with margin determination and physician interpretation and report	1/1/2026	12/31/2999
0899T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF) derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR) pharmacologic stress with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0900T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF) derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR) pharmacologic stress with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0901T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of bone marrow sampling port including imaging guidance when performed	1/1/2026	12/31/2999
0902T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	QTc interval derived by augmentative algorithmic analysis of input from an external patient-activated mobile ECG device	1/1/2026	12/31/2999
0903T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	1/1/2026	12/31/2999
0904T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	1/1/2026	12/31/2999
0905T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only	1/1/2026	12/31/2999
0906T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Concurrent optical and magnetic stimulation (COMS) therapy wound assessment and dressing care; first application total wound(s) surface area less than or equal to 50 sq cm	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0907T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Concurrent optical and magnetic stimulation (COMS) therapy wound assessment and dressing care; each additional application total wound(s) surface area less than or equal to 50 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0908T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Open implantation of integrated neurostimulation system vagus nerve including analysis and programming when performed	1/1/2026	12/31/2999
0909T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of integrated neurostimulation system vagus nerve including analysis and programming when performed	1/1/2026	12/31/2999
0910T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of integrated neurostimulation system vagus nerve	1/1/2026	12/31/2999
0911T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system vagus nerve; without programming by physician or other qualified health care professional	1/1/2026	12/31/2999
0912T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system vagus nerve; with simple programming by physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0913T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg drug-coated drug-eluting) including mechanical dilation by nondrug-delivery balloon angioplasty endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed imaging supervision interpretation and report single major coronary artery or branch	1/1/2026	12/31/2999
0914T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg drug-coated drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty coronary stent placement or coronary atherectomy including mechanical dilation by nondrug delivery balloon angioplasty endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed imaging supervision interpretation and report single major coronary artery or branch (List separately in addition to code for percutaneous coronary stent or atherectomy intervention)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0932T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
0933T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring including sensor calibration and deployment right heart catheterization transseptal puncture imaging guidance and radiological supervision and interpretation	1/1/2026	12/31/2999
0934T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of a wireless left atrial pressure sensor for up to 30 days including data from daily uploads of left atrial pressure recordings interpretation(s) and trend analysis with adjustments to the diuretics plan treatment paradigm thresholds medications or lifestyle modifications when performed and report(s) by a physician or other qualified health care professional	1/1/2026	12/31/2999
0936T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation therapy of retina single session	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0937T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording scanning analysis with report review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0938T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)	1/1/2026	12/31/2999
0939T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report	1/1/2026	12/31/2999
0940T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; Review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0941T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization	1/1/2026	12/31/2999
0942T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy flexible; with removal and replacement of prostatic urethral scaffold	1/1/2026	12/31/2999
0943T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy flexible; with removal of prostatic urethral scaffold	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0944T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	1/1/2026	12/31/2999
0945T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative assessment for abnormal (tumor) tissue in-vivo following partial mastectomy (eg lumpectomy) using computer-aided fluorescence imaging	1/1/2026	12/31/2999
0946T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure including data acquisition data preparation and transmission interpretation and report (including CT scan of the joint or extremity performed with paired views)	1/1/2026	12/31/2999
0951T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; initial placement including mastoidectomy placement of and attachment to sound processor	1/1/2026	12/31/2999
0952T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement with mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0953T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement without mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0954T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; replacement of sound processor only with attachment to existing transducers	1/1/2026	12/31/2999

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0955T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; removal including removal of sound processor and all implant components	1/1/2026	12/31/2999
0956T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Partial craniectomy channel creation and tunneling of electrode for sub-scalp implantation of an electrode array receiver and telemetry unit for continuous bilateral electroencephalography monitoring system including imaging guidance	1/1/2026	12/31/2999
0957T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision of sub-scalp implanted electrode array receiver and telemetry unit for electrode when required including imaging guidance	1/1/2026	12/31/2999
0958T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of sub-scalp implanted electrode array receiver and telemetry unit for continuous bilateral electroencephalography monitoring system including imaging guidance	1/1/2026	12/31/2999
0959T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system including imaging guidance	1/1/2026	12/31/2999
0960T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of sub-scalp implanted electrode array receiver and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system including imaging guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0961T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Shortwave infrared radiation imaging surgical pathology specimen to assist gross examination for lymph node localization in fibroadipose tissue per specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0962T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg reduced ejection fraction cardiac murmurs atrial fibrillation) with review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0967T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transanal insertion of endoluminal temporary colorectal anastomosis protection device including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system	1/1/2026	12/31/2999
0968T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of epicranial neurostimulator system including electrode array and pulse generator with connection to electrode array	1/1/2026	12/31/2999
0969T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of epicranial neurostimulator system	1/1/2026	12/31/2999
0970T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation benign breast tumor (eg fibroadenoma) percutaneous laser including imaging guidance when performed each tumor	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0971T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation malignant breast tumor(s) percutaneous laser including imaging guidance when performed unilateral	1/1/2026	12/31/2999
0972T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic classification of burn healing (ie healing or nonhealing) by noninvasive multispectral imaging including system set-up and acquisition selection and transmission of images with automated generation of report	1/1/2026	12/31/2999
0973T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement partial-thickness and/or full-thickness burn eschar requiring anesthesia (ie general anesthesia moderate sedation) including patient monitoring trunk arms legs; first 100 sq cm	1/1/2026	12/31/2999
0974T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement partial-thickness and/or full-thickness burn eschar requiring anesthesia (ie general anesthesia moderate sedation) including patient monitoring trunk arms legs; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0975T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement partial-thickness and/or full-thickness burn eschar requiring anesthesia (ie general anesthesia moderate sedation) including patient monitoring scalp neck hands feet and/or multiple digits; first 100 sq cm	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0976T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement partial-thickness and/or full-thickness burn eschar requiring anesthesia (ie general anesthesia moderate sedation) including patient monitoring scalp neck hands feet and/or multiple digits; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0977T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Upper gastrointestinal blood detection sensor capsule with interpretation and report	1/1/2026	12/31/2999
0981T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring including deployment of the sensor radiological supervision and interpretation right heart catheterization and inferior vena cava venography when performed	1/1/2026	12/31/2999
0982T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of implantable inferior vena cava pressure sensor physiologic parameter(s) (eg weight blood pressure pulse oximetry respiratory flow rate) initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0983T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days including at least weekly downloads of inferior vena cava area recordings interpretation(s) trend analysis and report(s) by a physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0984T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including all associated radiological supervision interpretation and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0985T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including all associated radiological supervision interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0986T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including all associated radiological supervision interpretation and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0987T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including all associated radiological supervision interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0990T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcervical instillation of biodegradable hydrogel materials intrauterine	1/1/2026	12/31/2999
0991T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy with low-energy lithotripsy and acoustically actuated microspheres including imaging	1/1/2026	12/31/2999
0992T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart including patient-specific clinical factors with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
0993T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat with concurrent computed tomography scan of the heart including patient-specific clinical factors with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0994T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm with aortic roadmapping balloon occlusion imaging guidance and radiological supervision and interpretation; percutaneous	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0995T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm with aortic roadmapping balloon occlusion imaging guidance and radiological supervision and interpretation; open	1/1/2026	12/31/2999
0996T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis with vitrectomy including removal of crystalline lens or dislocated intraocular lens prosthesis when performed	1/1/2026	12/31/2999
0997T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location dose and intensity for magnetic stimulation therapy derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram including automated data processing transmission analysis generation of treatment parameters with review interpretation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0998T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus utilizing magnetic resonance imaging-based neuronavigation with management per day	1/1/2026	12/31/2999
0999T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy harvesting of muscle progenitor cells including ultrasound guidance when performed	1/1/2026	12/31/2999
1000T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy administration of muscle progenitor cells into the urethral sphincter including cystoscopy and post-void residual ultrasound when performed	1/1/2026	12/31/2999
1001T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy injection of muscle progenitor cells into the external anal sphincter including ultrasound guidance when performed	1/1/2026	12/31/2999
1002T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Air displacement plethysmography whole-body composition assessment with interpretation and report	1/1/2026	12/31/2999
1003T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroplasty first carpometacarpal joint with distal trapezial and proximal first metacarpal prosthetic replacement (eg first carpometacarpal total joint)	1/1/2026	12/31/2999

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1004T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg contact group[s] gain bandpass filters) by physician or other qualified health care professional; without programming	1/1/2026	12/31/2999
1005T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg contact group[s] gain bandpass filters) by physician or other qualified health care professional; with programming first 15 minutes face-to-face time with physician or other qualified health care professional	1/1/2026	12/31/2999
1006T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg contact group[s] gain bandpass filters) by physician or other qualified health care professional; with programming each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1007T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electroencephalogram from implanted sub-scalp continuous bilateral electroencephalography monitoring system physician or other qualified health care professional review of recorded events analysis of spike and seizure detection interpretation and report up to 30 days of recording without video	1/1/2026	12/31/2999
1008T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of sub-scalp implanted continuous bilateral electroencephalography monitoring system device fitting initial set-up and patient education in wearing of system and use of equipment	1/1/2026	12/31/2999
1009T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of a sub-scalp implanted continuous bilateral electroencephalography monitoring system physician or other qualified health care professional review of recorded events analysis of spike and seizure detection interpretation and report up to 30 days of recording without video	1/1/2026	12/31/2999
1010T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computerized ophthalmic analysis of monocular eye movements using retinal-based eye-tracking without spatial calibration including fixation microsaccades drift and horizontal saccades when performed unilateral or bilateral with interpretation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1011T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation (PBM) therapy of oral cavity including placement of an oral device monitoring of patient tolerance to treatment and removal of the oral device	1/1/2026	12/31/2999
1012T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motorized ab interno trephination of sclera (sclerostomy) or trabecular meshwork (trabeculostomy) 1 or more including injection of antifibrotic agents when performed	1/1/2026	12/31/2999
1013T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopy surgical implantation or replacement of lower esophageal sphincter neurostimulator electrode array and neurostimulator pulse generator or receiver requiring pocket creation and connection between electrode array and pulse generator or receiver including cruroplasty and/or electronic analysis when performed	1/1/2026	12/31/2999
1014T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic revision or removal lower esophageal sphincter neurostimulator electrodes	1/1/2026	12/31/2999
1015T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal lower esophageal sphincter neurostimulator pulse generator or receiver	1/1/2026	12/31/2999

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1016T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg rate pulse amplitude and duration configuration of wave form battery status electrode selectability output modulation cycling impedance and patient measurements) lower esophageal sphincter neurostimulator pulse generator/transmitter; intraoperative with programming	1/1/2026	12/31/2999
1017T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg rate pulse amplitude and duration configuration of wave form battery status electrode selectability output modulation cycling impedance and patient measurements) lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent without reprogramming	1/1/2026	12/31/2999
1018T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg rate pulse amplitude and duration configuration of wave form battery status electrode selectability output modulation cycling impedance and patient measurements) lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent with reprogramming	1/1/2026	12/31/2999

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1020T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Raman spectroscopy of 1 or more skin lesions with probability score for malignant risk derived by algorithmic analysis of data from each lesion	1/1/2026	12/31/2999
1021T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Active thoracic irrigation (separate procedure)	1/1/2026	12/31/2999
1022T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement any method including imaging guidance; intra-abdominal/pelvic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
1023T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement any method including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
1024T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement any method including imaging guidance; soft tissue (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
1025T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alternating electric fields dosimetry and delivery-simulation modeling creation and selection of patient-specific array layouts and placement verification	1/1/2026	12/31/2999
A2001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix ac per square centimeter	4/15/2022	12/31/2999
A2002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirragen advanced wound matrix per square centimeter	4/15/2022	12/31/2999

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A2004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellistem 1 mg	4/15/2022	12/31/2999
A2005	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Microlyte matrix per square centimeter	4/15/2022	12/31/2999
A2006	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novosorb synpath dermal matrix per square centimeter	4/15/2022	12/31/2999
A2007	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata per square centimeter	4/15/2022	12/31/2999
A2008	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Theragenesis per square centimeter	4/15/2022	12/31/2999
A2009	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Symphony per square centimeter	4/15/2022	12/31/2999
A2010	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Apis per square centimeter	4/15/2022	12/31/2999
A2011	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supra sdrm per square centimeter	8/1/2022	12/31/2999
A2012	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Suprathel per square centimeter	8/1/2022	12/31/2999
A2013	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix fs per square centimeter	8/1/2022	12/31/2999

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A2014	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Omeza collagen matrix per 100 mg	4/1/2023	12/31/2999
A2015	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Phoenix wound matrix per square centimeter	4/1/2023	12/31/2999
A2016	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm b per square centimeter	4/1/2023	12/31/2999
A2017	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm glove each	4/1/2023	12/31/2999
A2018	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Permeaderm c per square centimeter	4/1/2023	12/31/2999
A2019	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3 marigen shield per square centimeter	9/1/2023	12/31/2999
A2020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ac5 advanced wound system (ac5)	9/1/2023	12/31/2999
A2021	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neomatrix per square centimeter	9/1/2023	12/31/2999
A2022	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovaburn or innovamatrix xl per square centimeter	10/1/2023	12/31/2999
A2023	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix pd 1 mg	10/1/2023	12/31/2999

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A2024	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Resolve matrix or xenopatch per square centimeter	10/1/2023	12/31/2999
A2025	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d per cubic centimeter	10/1/2023	12/31/2999
A2026	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata minimatrix 5 mg	4/1/2024	12/31/2999
A2027	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matriderm per square centimeter	5/15/2025	12/31/2999
A2028	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Micromatrix flex per mg	5/15/2025	12/31/2999
A2029	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirotract wound matrix sheet per cubic centimeter	5/15/2025	12/31/2999
A2030	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d fibers per milligram	9/15/2025	12/31/2999
A2031	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirodry wound matrix per square centimeter	9/15/2025	12/31/2999
A2032	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad matrix per square centimeter	9/15/2025	12/31/2999
A2033	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad morcells 4 milligrams	9/15/2025	12/31/2999

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A2034	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Foundation drs solo per square centimeter	9/15/2025	12/31/2999
A2035	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex p or theracor p or allacor p per milligram	9/15/2025	12/31/2999
A4540	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Distal transcutaneous electrical nerve stimulator stimulates peripheral nerves of the upper arm	5/15/2024	12/31/2999
A4542	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
A4543	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies for transcutaneous electrical nerve stimulator for nerves in the auricular region per month	5/15/2025	12/31/2999
A4560	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neuromuscular electrical stimulator (nmes) disposable replacement only	1/15/2024	12/31/2999
A4596	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system supplies and accessories per month	4/1/2023	12/31/2999
A7021	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories for lung expansion airway clearance continuous high frequency oscillation and nebulization device (e.g. handset nebulizer kit biofilter)	5/15/2025	12/31/2999
A7049	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Expiratory positive airway pressure intranasal resistance valve	9/1/2023	12/31/2999
A9285	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Inversion/eversion correction device	12/1/2020	12/31/2999

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C1052	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hemostatic agent gastrointestinal topical	5/15/2021	12/31/2999
C1735	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	6/15/2025	12/31/2999
C1736	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	6/15/2025	12/31/2999
C1823	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator neurostimulator (implantable) non-rechargeable with transvenous sensing and stimulation leads	4/1/2022	12/31/2999
C1827	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator neurostimulator (implantable) non-rechargeable with implantable stimulation lead and external paired stimulation controller	9/1/2023	12/31/2999
C1832	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autograft suspension including cell processing and application and all system components	5/15/2024	12/31/2999
C8002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	6/15/2025	12/31/2999
C8003	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia open includes measurements positioning and adjustments with imaging guidance (eg fluoroscopy)	12/15/2025	12/31/2999

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C9354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acellular pericardial tissue matrix of non-human origin (Veritas) per square centimeter	12/1/2020	12/31/2999
C9356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tendon porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet) per square centimeter	12/1/2020	12/31/2999
C9358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters	12/1/2020	12/31/2999
C9360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute native non-denatured collagen neonatal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters	12/1/2020	12/31/2999
C9363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Skin substitute Integra Meshed Bilayer Wound Matrix per square centimeter	5/15/2021	12/31/2999
C9364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Porcine implant Permacol per square centimeter	12/1/2020	12/31/2999
C9757	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and excision of herniated intervertebral disc and repair of annular defect with implantation of bone anchored annular closure device including annular defect measurement alignment and sizing assessment and image guidance; 1 interspace lumbar	8/1/2022	12/31/2999

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C9768	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure)	3/1/2021	12/31/2999
C9772	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization endovascular open or percutaneous tibial/peroneal artery(ies) with intravascular lithotripsy includes angioplasty within the same vessel (s) when performed	8/15/2021	12/31/2999
C9773	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s) includes angioplasty within the same vessel(s) when performed	8/15/2021	12/31/2999
C9774	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy includes angioplasty within the same vessel (s) when performed	8/15/2021	12/31/2999
C9775	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s) and atherectomy includes angioplasty within the same vessel (s) when performed	8/15/2021	12/31/2999
C9777	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophageal mucosal integrity testing by electrical impedance transoral includes esophagoscopy or esophagogastroduodenoscopy	8/15/2021	12/31/2999

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C9784	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastric restrictive procedure endoscopic sleeve gastroplasty with esophagogastroduodenoscopy and intraluminal tube insertion if performed including all system and tissue anchoring components	12/1/2023	12/31/2999
C9785	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic outlet reduction gastric pouch application with endoscopy and intraluminal tube insertion if performed including all system and tissue anchoring components	12/1/2023	12/31/2999
C9796	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g. porcine small intestine submucosa [sis])	7/1/2024	12/31/2999
C9807	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	6/15/2025	12/31/2999
E0469	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lung expansion airway clearance continuous high frequency oscillation and nebulization device	5/15/2025	12/31/2999
E0490	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle controlled by hardware remote	10/1/2023	12/31/2999

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E0491	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle used in conjunction with the power source and control electronics unit controlled by hardware remote 90-day supply	10/1/2023	12/31/2999
E0721	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous electrical nerve stimulator for nerves in the auricular region	5/15/2025	12/31/2999
E0732	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system any type	5/15/2024	12/31/2999
E0734	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
E0764	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	FUNCTIONAL NEUROMUSCULAR STIMULATION TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL USED FOR WALKING BY SPINAL CORD INJURED ENTIRE SYSTEM AFTER COMPLETION OF TRAINING PROGRAM	4/1/2022	12/31/2999
E1632	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wearable artificial kidney each	1/1/2023	12/31/2999
E3000	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech volume modulation system any type including all components and accessories	5/15/2024	12/31/2999
G0428	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex)	12/1/2020	12/31/2999

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G0460	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers including as applicable phlebotomy centrifugation or mixing and all other preparatory procedures administration and dressings per treatment	12/1/2020	12/31/2999
G0465	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers using an FDA-cleared device for this indication (includes as applicable administration dressings phlebotomy centrifugation or mixing and all other preparatory procedures per treatment)	4/1/2022	12/31/2999
G0552	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	6/15/2025	12/31/2999
G0553	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	6/15/2025	12/31/2999

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G0554	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	6/15/2025	12/31/2999
G9147	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous by any means guided by the results of measurements for:respiratory quotient; and/or urine urea nitrogen (UUN); and/or arterial venous or capillary glucose; and/or potassium concentration	12/1/2020	12/31/2999
K1004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low frequency ultrasonic diathermy treatment device for home use	12/1/2020	12/31/2999
K1036	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories (e.g. transducer) for low frequency ultrasonic diathermy treatment device per month	10/1/2023	12/31/2999
K1037	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	10/1/2024	12/31/2999
L5991	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Addition to lower extremity prostheses osseointegrated external prosthetic connector	10/1/2023	12/31/2999

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L8605	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable bulking agent dextranomer/hyaluronic acid copolymer implant anal canal 1 ml includes shipping and necessary supplies	12/1/2020	12/31/2999
M0076	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Prolotherapy	1/1/2023	12/31/2999
M0245	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravenous infusion bamlanivimab and etesevimab includes infusion and post administration monitoring	6/1/2023	12/31/2999
M0246	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravenous infusion bamlanivimab and etesevimab includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency	6/1/2023	12/31/2999
P9020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Platelet rich plasma each unit	12/1/2020	12/31/2999
Q0245	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection bamlanivimab and etesevimab 2100 mg	6/1/2023	12/31/2999
Q4103	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	OASIS BURN MATRIX PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4104	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD) PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4110	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	PRIMATRIX PER SQUARE CENTIMETER	5/15/2021	12/31/2999

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Q4111	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GAMMAGRAFT PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CYMETRA INJECTABLE 1CC	5/15/2021	12/31/2999
Q4113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GRAFTJACKET XPRESS INJECTABLE 1CC	5/15/2021	12/31/2999
Q4115	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ALLOSKIN PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	HYALOMATRIX PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4118	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MATRISTEM MICROMATRIX 1 MG	5/15/2021	12/31/2999
Q4123	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ALLOSKIN RT PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4124	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4125	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ARTHROFLEX PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4126	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Memoderm dermaspan tranzgraft or integuply per square centimeter	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4127	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TALYMED PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4130	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	STRATTICE TM PER SQUARE CENTIMETER	5/15/2021	12/31/2999
Q4134	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hmatrix per square centimeter	5/15/2021	12/31/2999
Q4135	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mediskin per square centimeter	5/15/2021	12/31/2999
Q4136	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ez-derm per square centimeter	5/15/2021	12/31/2999
Q4138	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence dryflex per square centimeter	12/1/2020	12/31/2999
Q4139	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniomatrix or biodmatrix injectable 1 cc	12/1/2020	12/31/2999
Q4140	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence per square centimeter	12/1/2020	12/31/2999
Q4141	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin ac per square centimeter	5/15/2021	12/31/2999
Q4142	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcm biologic tissue matrix per square centimeter	5/15/2021	12/31/2999

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Q4143	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repriza per square centimeter	5/15/2021	12/31/2999
Q4145	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epifix injectable 1 mg	12/1/2020	12/31/2999
Q4146	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tensix per square centimeter	5/15/2021	12/31/2999
Q4147	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Architect architect px or architect fx extracellular matrix per square centimeter	5/15/2021	12/31/2999
Q4148	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neox cord 1k neox cord rt or clarix cord 1k per square centimeter	12/1/2020	12/31/2999
Q4149	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Excellagen 0.1 cc	5/15/2021	12/31/2999
Q4150	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allowrap ds or dry per square centimeter	12/1/2020	12/31/2999
Q4152	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermapure per square centimeter	5/15/2021	12/31/2999
Q4153	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermavest and plurivest per square centimeter	12/1/2020	12/31/2999
Q4155	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neoxflo or clarixflo 1 mg	12/1/2020	12/31/2999

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Q4156	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neox 100 or clarix 100 per square centimeter	12/1/2020	12/31/2999
Q4157	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revitalon per square centimeter	12/1/2020	12/31/2999
Q4158	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3 per square centimeter	5/15/2021	12/31/2999
Q4160	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nushield per square centimeter	12/1/2020	12/31/2999
Q4161	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bio-connekt wound matrix per square centimeter	5/15/2021	12/31/2999
Q4162	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex flow bioskin flow 0.5 cc	12/1/2020	12/31/2999
Q4163	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex bioskin per square centimeter	12/1/2020	12/31/2999
Q4164	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Helicoll per square centimeter	5/15/2021	12/31/2999
Q4165	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Keramatrix or kerasorb per square centimeter	5/15/2021	12/31/2999
Q4166	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cytal per square centimeter	5/15/2021	12/31/2999

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

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Q4179	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Flowerderm per square centimeter	5/15/2021	12/31/2999
Q4180	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revita per square centimeter	12/1/2020	12/31/2999
Q4181	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio wound per square centimeter	12/1/2020	12/31/2999
Q4182	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcyte per square centimeter	5/15/2021	12/31/2999
Q4183	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft per square centimeter	12/1/2020	12/31/2999
Q4184	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta or cellesta duo per square centimeter	12/1/2020	12/31/2999
Q4185	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	12/1/2020	12/31/2999
Q4188	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioarmor per square centimeter	12/1/2020	12/31/2999
Q4189	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac 1 mg	12/1/2020	12/31/2999
Q4190	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac per square centimeter	12/1/2020	12/31/2999

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Q4191	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restorigin per square centimeter	12/1/2020	12/31/2999
Q4192	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restorigin 1 cc	12/1/2020	12/31/2999
Q4193	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Coll-e-derm per square centimeter	5/15/2021	12/31/2999
Q4194	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novachor per square centimeter	12/1/2020	12/31/2999
Q4195	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply per square centimeter	5/15/2021	12/31/2999
Q4196	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply am per square centimeter	5/15/2021	12/31/2999
Q4197	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Puraply xt per square centimeter	12/1/2020	12/31/2999
Q4198	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Genesis amniotic membrane per square centimeter	12/1/2020	12/31/2999
Q4199	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus matrix per square centimeter	4/15/2022	12/31/2999
Q4200	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Skin te per square centimeter	5/15/2021	12/31/2999

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Q4201	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matrion per square centimeter	12/1/2020	12/31/2999
Q4202	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Keroxx (2.5g/cc) 1cc	5/15/2021	12/31/2999
Q4203	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Derma-gide per square centimeter	5/15/2021	12/31/2999
Q4204	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap per square centimeter	12/1/2020	12/31/2999
Q4205	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Membrane graft or membrane wrap per square centimeter	12/1/2020	12/31/2999
Q4206	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Fluid flow or fluid GF 1 cc	12/1/2020	12/31/2999
Q4208	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novafix per square cenitmeter	12/1/2020	12/31/2999
Q4209	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft per square centimeter	12/1/2020	12/31/2999
Q4211	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnion bio or Axobiomembrane per square centimeter	12/1/2020	12/31/2999
Q4212	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allogen per cc	12/1/2020	12/31/2999

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Q4213	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ascent 0.5 mg	12/1/2020	12/31/2999
Q4214	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta cord per square centimeter	12/1/2020	12/31/2999
Q4215	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl ambient or axolotl cryo 0.1 mg	12/1/2020	12/31/2999
Q4216	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent cord per square centimeter	12/1/2020	12/31/2999
Q4217	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundfix BioWound Woundfix Plus BioWound Plus Woundfix Xplus or BioWound Xplus per square centimeter	12/1/2020	12/31/2999
Q4218	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgicord per square centimeter	12/1/2020	12/31/2999
Q4219	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft-dual per square centimeter	12/1/2020	12/31/2999
Q4220	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	BellaCell HD or Surederm per square centimeter	5/15/2021	12/31/2999
Q4221	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniowrap2 per square centimeter	12/1/2020	12/31/2999
Q4222	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Progenamatrix per square centimeter	5/15/2021	12/31/2999

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Q4224	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Human health factor 10 amniotic patch (hhf10-p) per square centimeter	8/1/2022	12/31/2999
Q4225	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniobind or dermabind tl per square centimeter	8/1/2022	12/31/2999
Q4226	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MyOwn skin includes harvesting and preparation procedures per square centimeter	10/1/2024	12/31/2999
Q4227	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore per square centimeter	12/1/2020	12/31/2999
Q4229	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex amniotic membrane per square centimeter	12/1/2020	12/31/2999
Q4230	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex flowable amnion per 0.5 cc	12/1/2020	12/31/2999
Q4231	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex p per cc	12/1/2020	12/31/2999
Q4232	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex per square centimeter	12/1/2020	12/31/2999
Q4233	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surfactor or nudyn per 0.5 cc	12/1/2020	12/31/2999
Q4234	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellerate per square centimeter	12/1/2020	12/31/2999

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Q4235	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniorepair or altiply per square centimeter	12/1/2020	12/31/2999
Q4236	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Carepatch per square centimeter	12/1/2020	12/31/2999
Q4237	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cryo-cord per square centimeter	12/1/2020	12/31/2999
Q4238	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Derm-maxx per square centimeter	7/1/2022	12/31/2999
Q4239	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio-maxx or amnio-maxx lite per square centimeter	12/1/2020	12/31/2999
Q4240	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corecyte for topical use only per 0.5 cc	12/1/2020	12/31/2999
Q4241	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Polycyte for topical use only per 0.5 cc	12/1/2020	12/31/2999
Q4242	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocyte plus per 0.5 cc	12/1/2020	12/31/2999
Q4245	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniotext per cc	12/1/2020	12/31/2999
Q4246	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Coretext or protext per cc	12/1/2020	12/31/2999

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

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Q4257	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Relese per square centimeter	8/1/2022	12/31/2999
Q4258	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Enverse per square centimeter	8/1/2022	12/31/2999
Q4259	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Celera dual layer or celera dual membrane per square centimeter	1/1/2023	12/31/2999
Q4260	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Signature apatch per square centimeter	1/1/2023	12/31/2999
Q4261	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tag per square centimeter	1/1/2023	12/31/2999
Q4262	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dual layer impax membrane per square centimeter	1/1/2023	12/31/2999
Q4263	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft tl per square centimeter	1/1/2023	12/31/2999
Q4264	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cocoon membrane per square centimeter	1/1/2023	12/31/2999
Q4265	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim tl per square centimeter	9/1/2023	12/31/2999
Q4266	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim membrane per square centimeter	9/1/2023	12/31/2999

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Q4267	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim dl per square centimeter	9/1/2023	12/31/2999
Q4268	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft ft per square centimeter	9/1/2023	12/31/2999
Q4269	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft xt per square centimeter	9/1/2023	12/31/2999
Q4270	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete sl per square centimeter	9/1/2023	12/31/2999
Q4271	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete ft per square centimeter	9/1/2023	12/31/2999
Q4272	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano a per square centimeter	12/1/2023	12/31/2999
Q4273	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aaa per square centimeter	12/1/2023	12/31/2999
Q4274	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano ac per square centimeter	12/1/2023	12/31/2999
Q4275	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aca per square centimeter	12/1/2023	12/31/2999
Q4276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orion per square centimeter	12/1/2023	12/31/2999

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Q4278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epieffect per square centimeter	12/1/2023	12/31/2999
Q4279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vendaje ac per square centimeter	7/1/2024	12/31/2999
Q4280	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcell amnio matrix per square centimeter	12/1/2023	12/31/2999
Q4281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Barrera sl or barrera dl per square centimeter	12/1/2023	12/31/2999
Q4282	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus dual per square centimeter	12/1/2023	12/31/2999
Q4284	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind sl per square centimeter	12/1/2023	12/31/2999
Q4285	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nudyn dl or nudyn dl mesh per square centimeter	10/1/2023	12/31/2999
Q4286	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nudyn sl or nudyn slw per square centimeter	10/1/2023	12/31/2999
Q4287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind dl per square centimeter	7/1/2024	12/31/2999
Q4288	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind ch per square centimeter	7/1/2024	12/31/2999

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Q4289	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revoshield + amniotic barrier per square centimeter	7/1/2024	12/31/2999
Q4290	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Membrane wrap-hydro per square centimeter	7/1/2024	12/31/2999
Q4291	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lamellas xt per square centimeter	7/1/2024	12/31/2999
Q4292	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lamellas per square centimeter	7/1/2024	12/31/2999
Q4293	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso dl per square centimeter	7/1/2024	12/31/2999
Q4294	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio quad-core per square centimeter	7/1/2024	12/31/2999
Q4295	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio tri-core amniotic per square centimeter	7/1/2024	12/31/2999
Q4296	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Rebound matrix per square centimeter	7/1/2024	12/31/2999
Q4297	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Emerge matrix per square centimeter	7/1/2024	12/31/2999
Q4298	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnicore pro per square centimeter	7/1/2024	12/31/2999

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Q4299	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnicore pro+ per square centimeter	7/1/2024	12/31/2999
Q4300	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso tl per square centimeter	7/1/2024	12/31/2999
Q4301	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Activate matrix per square centimeter	7/1/2024	12/31/2999
Q4302	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete aca per square centimeter	7/1/2024	12/31/2999
Q4303	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete aa per square centimeter	7/1/2024	12/31/2999
Q4305	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion ac tri-layer per square centimeter	4/1/2024	12/31/2999
Q4306	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion ac per square centimeter	4/1/2024	12/31/2999
Q4307	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	American amnion per square centimeter	4/1/2024	12/31/2999
Q4308	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sanopellis per square centimeter	4/1/2024	12/31/2999
Q4309	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Via matrix per square centimeter	4/1/2024	12/31/2999

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

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

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Q4330	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Total per square centimeter	7/1/2024	12/31/2999
Q4331	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl graft per square centimeter	7/1/2024	12/31/2999
Q4332	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl dualgraft per square centimeter	7/1/2024	12/31/2999
Q4333	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ardeograft per square centimeter	7/1/2024	12/31/2999
Q4334	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 1 per square centimeter	5/15/2025	12/31/2999
Q4335	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 2 per square centimeter	5/15/2025	12/31/2999
Q4336	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent c per square centimeter	5/15/2025	12/31/2999
Q4337	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent trident per square centimeter	5/15/2025	12/31/2999
Q4338	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent velos per square centimeter	5/15/2025	12/31/2999
Q4339	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent vericlen per square centimeter	5/15/2025	12/31/2999

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Q4340	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simpligraft per square centimeter	5/15/2025	12/31/2999
Q4341	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simplimax per square centimeter	5/15/2025	12/31/2999
Q4342	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Theramend per square centimeter	5/15/2025	12/31/2999
Q4343	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermacyte ac matrix amniotic membrane allograft per square centimeter	5/15/2025	12/31/2999
Q4344	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tri-membrane wrap per square centimeter	5/15/2025	12/31/2999
Q4345	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matrix hd allograft dermis per square centimeter	5/15/2025	12/31/2999
Q4346	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Shelter dm matrix, per square centimeter	6/15/2025	12/31/2999
Q4347	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Rampart dl matrix, per square centimeter	6/15/2025	12/31/2999
Q4348	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sentry sl matrix, per square centimeter	6/15/2025	12/31/2999
Q4349	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mantle dl matrix, per square centimeter	6/15/2025	12/31/2999

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Q4350	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palisade dm matrix, per square centimeter	6/15/2025	12/31/2999
Q4351	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Enclose tl matrix, per square centimeter	6/15/2025	12/31/2999
Q4352	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Overlay sl matrix, per square centimeter	6/15/2025	12/31/2999
Q4353	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xceed tl matrix, per square centimeter	6/15/2025	12/31/2999
Q4354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen dual-layer membrane per square centimeter	9/15/2025	12/31/2999
Q4355	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend xplus membrane and abiomend xplus hydromembrane per square centimeter	9/15/2025	12/31/2999
Q4356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend membrane and abiomend hydromembrane per square centimeter	9/15/2025	12/31/2999
Q4357	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap plus per square centimeter	9/15/2025	12/31/2999
Q4358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap dual per square centimeter	9/15/2025	12/31/2999
Q4359	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Choriply per square centimeter	9/15/2025	12/31/2999

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Q4360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amchoplast fd per square centimeter	9/15/2025	12/31/2999
Q4361	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epixpress per square centimeter	9/15/2025	12/31/2999
Q4362	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus disk per square centimeter	9/15/2025	12/31/2999
Q4363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon membrane and hydromembrane per square centimeter	9/15/2025	12/31/2999
Q4364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon xplus membrane and xplus hydromembrane per square centimeter	9/15/2025	12/31/2999
Q4365	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon dual-layer membrane per square centimeter	9/15/2025	12/31/2999
Q4366	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dual layer amnio burgeon x-membrane per square centimeter	9/15/2025	12/31/2999
Q4367	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore sl per square centimeter	9/15/2025	12/31/2999
S2117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroereisis subtalar	12/1/2020	12/31/2999
S2300	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroscopy shoulder surgical; with thermally-induced capsulorrhaphy	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S3650	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test hormone level; during menopause	12/1/2020	12/31/2999
S3652	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test hormone level; to assess preterm labor risk	12/1/2020	12/31/2999
S9001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Home uterine monitor with or without associated nursing services	9/1/2020	12/31/2999

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

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

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

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