



**2026 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List - Fully Insured**  
**Effective 1/1/2026 through 1/1/2027**  
**(Updated May 2026)**

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|--|---|
| <p><b>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:</b></p> <ul style="list-style-type: none"> <li>- Subject to a medical necessity review,</li> <li>- Candidates for a Recommended Clinical Review,</li> <li>- Not a benefit for our members,</li> <li>- Considered experimental, investigational and unproven (EIU), or</li> <li>- Not on our prior authorization list (with some exceptions based on members' benefit plans)</li> </ul> <p><b>Except as otherwise noted in the date column, these codes are effective on or before January 1, 2026</b></p> | <p><b>Utilization Management Process</b></p> <p>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.</p> |
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| Procedure Code Groups                         | Procedure Code Group Description  |
|---|---|
| Medical Policy Criteria (MP Criteria)         | <a href="#">Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.</a><br><br>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 |
|----------------|------------------|--------------------------|----------------|-------------|
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| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 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  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A0392          | ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0394          | ALS specialized service disposable supplies; IV drug therapy  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0396          | ALS specialized service disposable supplies; esophageal intubation  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0398          | ALS routine disposable supplies   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0420          | Ambulance waiting time (ALS or BLS), one half (1/2) hour increments   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A0422          | Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0424          | Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0425          | Ground mileage, per statute mile  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0426          | Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1)                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0427          | Ambulance service, advanced life support, emergency transport, Level 1 (ALS1-Emergency)                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A0428          | Ambulance service, basic life support, non-emergency transport (BLS)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0429          | Ambulance service, basic life support, emergency transport (BLS-Emergency)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0431          | Ambulance service, conventional air services, transport, one way (rotary wing)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0432          | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |
| A0433          | Advanced life support, Level 2 (ALS2)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
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| 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  |
| 797            | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                                  | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 11950          | Subcutaneous injection of filling material (eg, collagen); 1 cc or less               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 11951          | Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 11952          | Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 11954          | Subcutaneous injection of filling material (eg, collagen); over 10.0 cc               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 11960          | Insertion of tissue expander(s) for other than breast, including subsequent expansion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2006       | 12/31/2999  |
| 11970          | Replacement of tissue expander with permanent implant                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 11980          | Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15011          | Harvest of skin for skin cell suspension autograft; first 25 sq cm or less  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15012          | Harvest of skin for skin cell suspension autograft; first 25 sq cm or less; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15013          | Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15014          | Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15015          | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms legs; first 480 sq cm or less  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 15016          | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15017          | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15018          | Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2025      | 12/31/2999  |
| 15271          | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023       | 12/31/2999  |
| 15272          | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023       | 12/31/2999  |
| 15273          | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023       | 12/31/2999  |

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

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

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 15775          | Punch graft for hair transplant; 1 to 15 punch grafts  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15776          | Punch graft for hair transplant; more than 15 punch grafts                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15780          | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005       | 12/31/2999  |
| 15781          | Dermabrasion; segmental, face  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005       | 12/31/2999  |
| 15782          | Dermabrasion; regional, other than face  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15783          | Dermabrasion; superficial, any site (eg, tattoo removal)                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
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| 15786          | Abrasion; single lesion (eg, keratosis, scar)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005       | 12/31/2999  |
| 15787          | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005       | 12/31/2999  |
| 15788          | Chemical peel, facial; epidermal  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15789          | Chemical peel, facial; dermal   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15792          | Chemical peel, nonfacial; epidermal   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15793          | Chemical peel, nonfacial; dermal  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
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| 15820          | Blepharoplasty, lower eyelid;   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15821          | Blepharoplasty, lower eyelid; with extensive herniated fat pad        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15822          | Blepharoplasty, upper eyelid;   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15823          | Blepharoplasty, upper eyelid; with excessive skin weighting down lid  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 15825          | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15828          | Rhytidectomy; cheek, chin, and neck                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |

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| 15829          | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15830          | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007       | 12/31/2999  |
| 15832          | Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh                                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15833          | Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg                                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15834          | Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip                                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15835          | Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |

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

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| 15877          | Suction assisted lipectomy; trunk   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15878          | Suction assisted lipectomy; upper extremity   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 15879          | Suction assisted lipectomy; lower extremity   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 17106          | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005       | 12/31/2999  |
| 17107          | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 17108          | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
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| 17380          | Electrolysis epilation, each 30 minutes   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 19105          | Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 15999          | Unlisted procedure, excision pressure ulcer   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 19300          | Mastectomy for gynecomastia   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/1/2020       | 12/31/2999  |
| 19303          | Mastectomy, simple, complete  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2007       | 12/31/2999  |
| 19318          | Breast reduction  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/15/2023      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 19325          | Breast augmentation with implant  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 19328          | Removal of intact breast implant  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 19330          | Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 17999          | Unlisted procedure, skin, mucous membrane and subcutaneous tissue                         | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 19340          | Insertion of breast implant on same day of mastectomy (ie, immediate)                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 19342          | Insertion or replacement of breast implant on separate day from mastectomy                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2005       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 19350          | Nipple/areola reconstruction   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017       | 12/31/2999  |
| 19355          | Correction of inverted nipples   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 19357          | Tissue expander placement in breast reconstruction, including subsequent expansion(s)                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017       | 12/31/2999  |
| 19370          | Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 19371          | Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 19499          | Unlisted procedure, breast   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 20979          | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 20982          | Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/15/2007      | 12/31/2999  |
| 19499          | Unlisted procedure, breast   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 20983          | Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2020       | 12/31/2999  |
| 20985          | Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2025      | 12/31/2999  |
| 21032          | Excision of maxillary torus palatinus  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 21083          | Impression and custom preparation; palatal lift prosthesis   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 21120          | Genioplasty; augmentation (autograft, allograft, prosthetic material)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 20999          | Unlisted procedure, musculoskeletal system, general   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 21121          | Genioplasty; sliding osteotomy, single piece  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 21122          | Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 21123          | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 21089          | Unlisted maxillofacial prosthetic procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 21244          | Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 21245          | Reconstruction of mandible or maxilla, subperiosteal implant; partial                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 21246          | Reconstruction of mandible or maxilla, subperiosteal implant; complete                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 21248          | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 21249          | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 21299          | Unlisted craniofacial and maxillofacial procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 21499          | Unlisted musculoskeletal procedure, head  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 21685          | Hyoid myotomy and suspension                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |
| 21899          | Unlisted procedure, neck or thorax                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 22899          | Unlisted procedure, spine                           | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 22999          | Unlisted procedure, abdomen, musculoskeletal system | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 23929          | Unlisted procedure, shoulder                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 24999          | Unlisted procedure, humerus or elbow                | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |

| Procedure Code | Code Description                        | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 23929          | Unlisted procedure, shoulder            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2017      | 12/31/2999  |
| 25999          | Unlisted procedure, forearm or wrist    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 26989          | Unlisted procedure, hands or fingers    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 27299          | Unlisted procedure, pelvis or hip joint | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 27299          | Unlisted procedure, pelvis or hip joint | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2017       | 12/31/2999  |
| 27599          | Unlisted procedure, femur or knee       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |

| Procedure Code | Code Description                                | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 27899          | Unlisted procedure, leg or ankle                | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 27702          | Arthroplasty, ankle; with implant (total ankle) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/15/2009     | 12/31/2999  |
| 28899          | Unlisted procedure, foot or toes                | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 27703          | Arthroplasty, ankle; revision, total ankle      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2015       | 12/31/2999  |
| 29799          | Unlisted procedure, casting or strapping        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 29999          | Unlisted procedure, arthroscopy                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description                      | Code Group & Description   | Effective Date | Ending Date |
|----------------|---------------------------------------|--|----------------|-------------|
| 30999          | Unlisted procedure, nose              | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 29999          | Unlisted procedure, arthroscopy       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2017      | 12/31/2999  |
| 31299          | Unlisted procedure, accessory sinuses | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 31599          | Unlisted procedure, larynx            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 31899          | Unlisted procedure, trachea, bronchi  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 32999          | Unlisted procedure, lungs and pleura  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 31647          | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 31648          | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 31649          | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 31651          | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s]) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 32994          | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018       | 12/31/2999  |
| 32998          | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2007       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 33202          | Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33203          | Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy)                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33207          | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33208          | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33999          | Unlisted procedure, cardiac surgery   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 33211          | Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 33213          | Insertion of pacemaker pulse generator only; with existing dual leads  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 36299          | Unlisted procedure, vascular injection   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 33214          | Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33217          | Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33220          | Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |
| 33221          | Insertion of pacemaker pulse generator only; with existing multiple leads  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 33222          | Relocation of skin pocket for pacemaker   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33223          | Relocation of skin pocket for implantable defibrillator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33224          | Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33225          | Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2006      | 12/31/2999  |
| 33226          | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33228          | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 33229          | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33230          | Insertion of implantable defibrillator pulse generator only; with existing dual leads                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33231          | Insertion of implantable defibrillator pulse generator only; with existing multiple leads                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33233          | Removal of permanent pacemaker pulse generator only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33235          | Removal of transvenous pacemaker electrode(s); dual lead system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33237          | Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 33238          | Removal of permanent transvenous electrode(s) by thoracotomy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33241          | Removal of implantable defibrillator pulse generator only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33243          | Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33244          | Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction                                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33249          | Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33263          | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 33264          | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| 33285          | Insertion, subcutaneous cardiac rhythm monitor, including programming   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |
| 33289          | Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |
| 33361          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |
| 33362          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |
| 33363          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 33364          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015      | 12/31/2999  |
| 33365          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015      | 12/31/2999  |
| 33366          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014       | 12/31/2999  |
| 33367          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |
| 33368          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |
| 33369          | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 33418          | Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016      | 12/31/2999  |
| 33477          | Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016       | 12/31/2999  |
| 33548          | Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |
| 33927          | Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018       | 12/31/2999  |
| 33928          | Removal and replacement of total replacement heart system (artificial heart)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018       | 12/31/2999  |
| 33999          | Unlisted procedure, cardiac surgery  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017      | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 36476          | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006       | 12/31/2999  |
| 36478          | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006       | 12/31/2999  |
| 36479          | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006       | 12/31/2999  |
| 36482          | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019       | 12/31/2999  |
| 36483          | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 36522          | Photopheresis, extracorporeal  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 37215          | Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2006     | 12/31/2999  |
| 37216          | Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 37217          | Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2014     | 12/31/2999  |
| 37218          | Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 37241          | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| 37501          | Unlisted vascular endoscopy procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37242          | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| 37243          | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| 37244          | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 37254          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37255          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37256          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37257          | 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)                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37258          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37259          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37260          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37261          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37262          | 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)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37263          | 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  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 37799          | Unlisted procedure, vascular surgery   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37264          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 38129          | Unlisted laparoscopy procedure, spleen   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37265          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37266          | 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)                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37267          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37268          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37269          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37270          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37271          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37272          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37273          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37274          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37275          | 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        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 37276          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37277          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 37278          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 37279          | 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)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 38589          | Unlisted laparoscopy procedure, lymphatic system   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 37280          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 38999          | Unlisted procedure, hemic or lymphatic system  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37281          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 39499          | Unlisted procedure, mediastinum  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 37282          | 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  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 39599          | Unlisted procedure, diaphragm   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37283          | 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<br>(List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 40799          | Unlisted procedure, lips  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 37284          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 40899          | Unlisted procedure, vestibule of mouth  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37285          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 37286          | 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  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 41599          | Unlisted procedure, tongue, floor of mouth   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37287          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 41899          | Unlisted procedure, dentoalveolar structures  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37288          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 37289          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 37290          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 42299          | Unlisted procedure, palate, uvula   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37291          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 42699          | Unlisted procedure, salivary glands or ducts   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37292          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 37293          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 42999          | Unlisted procedure, pharynx, adenoids, or tonsils  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37294          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 37295          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 37296          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37297          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 37298          | 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   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 37299          | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 43289          | Unlisted laparoscopy procedure, esophagus   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 37700          | Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2006       | 12/31/2999  |
| 37718          | Ligation, division, and stripping, short saphenous vein   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2006       | 12/31/2999  |
| 37722          | Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2006       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 37785          | Ligation, division, and/or excision of varicose vein cluster(s), 1 leg                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2006       | 12/31/2999  |
| 43499          | Unlisted procedure, esophagus  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 38204          | Management of recipient hematopoietic progenitor cell donor search and cell acquisition                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 38205          | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 43659          | Unlisted laparoscopy procedure, stomach  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 38207          | Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 38208          | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 38209          | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 38210          | Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 38211          | Transplant preparation of hematopoietic progenitor cells; tumor cell depletion   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 38212          | Transplant preparation of hematopoietic progenitor cells; red blood cell removal   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 38213          | Transplant preparation of hematopoietic progenitor cells; platelet depletion   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 38214          | Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion                                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 38215          | Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 38232          | Bone marrow harvesting for transplantation; autologous   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2012       | 12/31/2999  |
| 38240          | Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 38308          | Lymphangiomy or other operations on lymphatic channels   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2014      | 12/31/2999  |
| 43999          | Unlisted procedure, stomach  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 44238          | Unlisted laparoscopy procedure, intestine (except rectum)   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 44799          | Unlisted procedure, small intestine                         | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 44899          | Unlisted procedure, Meckel's diverticulum and the mesentery | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 44979          | Unlisted laparoscopy procedure, appendix                    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 45399          | Unlisted procedure, colon                                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2015       | 12/31/2999  |
| 41120          | Glossectomy; less than one-half tongue                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 45499          | Unlisted laparoscopy procedure, rectum   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006       | 12/31/2999  |
| 41512          | Tongue base suspension, permanent suture technique                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2009       | 12/31/2999  |
| 45999          | Unlisted procedure, rectum   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 41530          | Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2024       | 12/31/2999  |
| 46999          | Unlisted procedure, anus   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 41872          | Gingivoplasty, each quadrant (specify)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2024       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 47379          | Unlisted laparoscopic procedure, liver                                    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 42140          | Uvulectomy, excision of uvula   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 1/14/2026   |
| 47399          | Unlisted procedure, liver   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 42145          | Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 47579          | Unlisted laparoscopy procedure, biliary tract                             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 47999          | Unlisted procedure, biliary tract   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 48999          | Unlisted procedure, pancreas   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 49329          | Unlisted laparoscopy procedure, abdomen, peritoneum and omentum  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 49659          | Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 42950          | Pharyngoplasty (plastic or reconstructive operation on pharynx)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |
| 49999          | Unlisted procedure, abdomen, peritoneum and omentum  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 43257          | Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2010       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 50549          | Unlisted laparoscopy procedure, renal  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 43281          | Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 43284          | Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2017       | 12/31/2999  |
| 43289          | Unlisted laparoscopy procedure, esophagus  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2017       | 12/31/2999  |
| 50949          | Unlisted laparoscopy procedure, ureter   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 51999          | Unlisted laparoscopy procedure, bladder  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 43632          | Gastrectomy, partial, distal; with gastrojejunostomy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2023       | 12/31/2999  |
| 43633          | Gastrectomy, partial, distal; with Roux-en-Y reconstruction  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2007       | 12/31/2999  |
| 43634          | Gastrectomy, partial, distal; with formation of intestinal pouch   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 53899          | Unlisted procedure, urinary system   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 43644          | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 43645          | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2019      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 43770          | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 43771          | Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 43772          | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 43773          | Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 43774          | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 54699          | Unlisted laparoscopy procedure, testis   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 43775          | Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2010       | 12/31/2999  |
| 55559          | Unlisted laparoscopy procedure, spermatic cord   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 43820          | Gastrojejunostomy; without vagotomy  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 43842          | Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/1/2020       | 12/31/2999  |
| 43843          | Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 55899          | Unlisted procedure, male genital system  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 43845          | Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2009      | 12/31/2999  |
| 43846          | Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 43847          | Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 43848          | Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 43860          | Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 43886          | Gastric restrictive procedure, open; revision of subcutaneous port component only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 43887          | Gastric restrictive procedure, open; removal of subcutaneous port component only                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 43888          | Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 58578          | Unlisted laparoscopy procedure, uterus   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58579          | Unlisted hysteroscopy procedure, uterus  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58679          | Unlisted laparoscopy procedure, oviduct, ovary   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58999          | Unlisted procedure, female genital system (nonobstetrical)                                       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 59897          | Unlisted fetal invasive procedure, including ultrasound guidance, when performed | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 59898          | Unlisted laparoscopy procedure, maternity care and delivery                      | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 59899          | Unlisted procedure, maternity care and delivery                                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 60659          | Unlisted laparoscopy procedure, endocrine system                                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 60699          | Unlisted procedure, endocrine system   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 47370          | Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 47382          | Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 47383          | Ablation, 1 or more liver tumor(s), percutaneous, cryoablation  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| 48160          | Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |
| 50250          | Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2008       | 12/31/2999  |
| 50360          | Renal allotransplantation, implantation of graft; without recipient nephrectomy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2016      | 12/31/2999  |
| 50541          | Laparoscopy, surgical; ablation of renal cysts  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2005       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 50542          | Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 50592          | Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2006       | 12/31/2999  |
| 50593          | Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2008       | 12/31/2999  |
| 51715          | Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2007       | 12/31/2999  |
| 64999          | Unlisted procedure, nervous system   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 52327          | Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2017       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 52441          | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2015      | 12/31/2999  |
| 52442          | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2015      | 12/31/2999  |
| 52443          | Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2026       | 6/14/2026   |
| 66999          | Unlisted procedure, anterior segment of eye  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 67299          | Unlisted procedure, posterior segment  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 67399          | Unlisted procedure, extraocular muscle   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 53865          | Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 6/14/2026   |
| 67599          | Unlisted procedure, orbit   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 53866          | Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2026       | 6/14/2026   |
| 54125          | Amputation of penis; complete   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 54400          | Insertion of penile prosthesis; non-inflatable (semi-rigid)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 54401          | Insertion of penile prosthesis; inflatable (self-contained)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 67999          | Unlisted procedure, eyelids   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 54405          | Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 68399          | Unlisted procedure, conjunctiva   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 54406          | Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 68899          | Unlisted procedure, lacrimal system   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 54408          | Repair of component(s) of a multi-component, inflatable penile prosthesis   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 54410          | Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 54411          | Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 69399          | Unlisted procedure, external ear   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 54415          | Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 54416          | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 54417          | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 54660          | Insertion of testicular prosthesis (separate procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 55706          | Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/15/2013     | 12/31/2999  |
| 55880          | Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2021       | 6/14/2026   |
| 69799          | Unlisted procedure, middle ear   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 69949          | Unlisted procedure, inner ear  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 55899          | Unlisted procedure, male genital system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2017      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 69979          | Unlisted procedure, temporal bone, middle fossa approach                | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 76496          | Unlisted fluoroscopic procedure (eg, diagnostic, interventional)        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 55970          | Intersex surgery; male to female  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 76497          | Unlisted computed tomography procedure (eg, diagnostic, interventional) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 55980          | Intersex surgery; female to male  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 76498          | Unlisted magnetic resonance procedure (eg, diagnostic, interventional)  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 56805          | Clitoroplasty for intersex state                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 76499          | Unlisted diagnostic radiographic procedure                             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 56810          | Perineoplasty, repair of perineum, nonobstetrical (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2008       | 12/31/2999  |
| 76999          | Unlisted ultrasound procedure (eg, diagnostic, interventional)         | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 57291          | Construction of artificial vagina; without graft                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 77299          | Unlisted procedure, therapeutic radiology clinical treatment planning  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 57292          | Construction of artificial vagina; with graft  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 77399          | Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 57296          | Revision (including removal) of prosthetic vaginal graft; open abdominal approach                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2007       | 12/31/2999  |
| 77499          | Unlisted procedure, therapeutic radiology treatment management                                       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 57335          | Vaginoplasty for intersex state  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2006       | 12/31/2999  |
| 77799          | Unlisted procedure, clinical brachytherapy   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 57426          | Revision (including removal) of prosthetic vaginal graft, laparoscopic approach                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2010       | 12/31/2999  |
| 78099          | Unlisted endocrine procedure, diagnostic nuclear medicine  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58321          | Artificial insemination; intra-cervical  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 78199          | Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58322          | Artificial insemination; intra-uterine   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 78299          | Unlisted gastrointestinal procedure, diagnostic nuclear medicine                                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 58323          | Sperm washing for artificial insemination  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 78399          | Unlisted musculoskeletal procedure, diagnostic nuclear medicine   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 78499          | Unlisted cardiovascular procedure, diagnostic nuclear medicine  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 78599          | Unlisted respiratory procedure, diagnostic nuclear medicine   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 78699          | Unlisted nervous system procedure, diagnostic nuclear medicine  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 78799          | Unlisted genitourinary procedure, diagnostic nuclear medicine   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58580          | Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 78999          | Unlisted miscellaneous procedure, diagnostic nuclear medicine | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 79999          | Radiopharmaceutical therapy, unlisted procedure               | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 80299          | Quantitation of therapeutic drug, not elsewhere specified     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 58750          | Tubotubal anastomosis   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/15/2008      | 12/31/2999  |
| 81099          | Unlisted urinalysis procedure                                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 81479          | Unlisted molecular pathology procedure                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2013       | 12/31/2999  |
| 81599          | Unlisted multianalyte assay with algorithmic analysis         | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2013       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 59072          | Fetal umbilical cord occlusion, including ultrasound guidance   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2023      | 12/31/2999  |
| 59074          | Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2022      | 12/31/2999  |
| 59076          | Fetal shunt placement, including ultrasound guidance  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2023      | 12/31/2999  |
| 84999          | Unlisted chemistry procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 6/20/2014      | 12/31/2999  |
| 60699          | Unlisted procedure, endocrine system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2022      | 12/31/2999  |
| 85999          | Unlisted hematology and coagulation procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 61635          | Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2019      | 12/31/2999  |
| 61645          | Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2016       | 12/31/2999  |
| 61715          | Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target intracranial, including stereotactic navigation and frame placement, when performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| 61889          | Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| 86486          | Skin test; unlisted antigen, each   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 61891          | Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 61892          | Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| 86849          | Unlisted immunology procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 86999          | Unlisted transfusion medicine procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 62268          | Percutaneous aspiration, spinal cord cyst or syrinx   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 63266          | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 87797          | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 63268          | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 87798          | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| 63271          | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 87799          | Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| 63273          | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 87899          | Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 63276          | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 87999          | Unlisted microbiology procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 63278          | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 88099          | Unlisted necropsy (autopsy) procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 63295          | Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| 88199          | Unlisted cytopathology procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 88299          | Unlisted cytogenetic study   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2014     | 12/31/2999  |
| 64566          | Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |
| 64568          | Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2022       | 12/31/2999  |
| 88399          | Unlisted surgical pathology procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 64575          | Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2022       | 12/31/2999  |
| 88749          | Unlisted in vivo (eg, transcutaneous) laboratory service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2011       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 64590          | Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2022       | 12/31/2999  |
| 89240          | Unlisted miscellaneous pathology test  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 64596          | Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| 64597          | Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| 64620          | Destruction by neurolytic agent, intercostal nerve   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2025      | 12/31/2999  |
| 64624          | Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2023      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 64628          | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2025      | 12/31/2999  |
| 64629          | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2025      | 12/31/2999  |
| 64640          | Destruction by neurolytic agent; other peripheral nerve or branch   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/15/2021      | 12/31/2999  |
| 64818          | Sympathectomy, lumbar   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2026       | 12/31/2999  |
| 89398          | Unlisted reproductive medicine laboratory procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2010       | 12/31/2999  |
| 90399          | Unlisted immune globulin  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 65760          | Keratomileusis  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 65770          | Keratoprosthesis  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| 90749          | Unlisted vaccine/toxoid   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 66174          | Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/15/2012      | 12/31/2999  |
| 66175          | Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/15/2012      | 12/31/2999  |
| 66179          | Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2015       | 12/31/2999  |
| 66180          | Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2021       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 66183          | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| 66989          | Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2022      | 12/31/2999  |
| 90899          | Unlisted psychiatric service or procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 66991          | Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2022      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 90999          | Unlisted dialysis procedure, inpatient or outpatient   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 67516          | Suprachoroidal space injection of pharmacologic agent (separate procedure)                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| 67901          | Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 67902          | Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 67903          | Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 67904          | Repair of blepharoptosis; (tarso) levator resection or advancement, external approach                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 67906          | Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 91299          | Unlisted diagnostic gastroenterology procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 67908          | Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 92499          | Unlisted ophthalmological service or procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 69090          | Ear piercing  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2020       | 12/31/2999  |
| 69300          | Otoplasty, protruding ear, with or without size reduction   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 69705          | Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/15/2021      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 69706          | Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/15/2021      | 12/31/2999  |
| 69728          | Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2023       | 12/31/2999  |
| 92700          | Unlisted otorhinolaryngological service or procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 76120          | Cineradiography/videoradiography, except where specifically included   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| 76125          | Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| 93799          | Unlisted cardiovascular service or procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 93998          | Unlisted noninvasive vascular diagnostic study  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012       | 12/31/2999  |
| 76940          | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2005       | 12/31/2999  |
| 94799          | Unlisted pulmonary service or procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 95199          | Unlisted allergy/clinical immunologic service or procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 95999          | Unlisted neurological or neuromuscular diagnostic procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 96379          | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2009       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 96549          | Unlisted chemotherapy procedure  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 96999          | Unlisted special dermatological service or procedure                               | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 97039          | Unlisted modality (specify type and time if constant attendance)                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 97139          | Unlisted therapeutic procedure (specify)   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 86353          | Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| 97799          | Unlisted physical medicine/rehabilitation service or procedure                     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 99050          | Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99056          | Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99058          | Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99070          | Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99075          | Medical testimony   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99078          | Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 99080          | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99082          | Unusual travel (eg, transportation and escort of patient)  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 86910          | Blood typing, for paternity testing, per individual; ABO, Rh and MN  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 99199          | Unlisted special service, procedure or report  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| 99429          | Unlisted preventive medicine service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99499          | Unlisted evaluation and management service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| 99600          | Unlisted home visit service or procedure   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 86911          | Blood typing, for paternity testing, per individual; each additional antigen system | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 0101T          | Extracorporeal shock wave involving musculoskeletal system, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2005       | 12/31/2999  |
| 88000          | Necropsy (autopsy), gross examination only; without CNS                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88005          | Necropsy (autopsy), gross examination only; with brain                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88007          | Necropsy (autopsy), gross examination only; with brain and spinal cord              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88012          | Necropsy (autopsy), gross examination only; infant with brain                       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88014          | Necropsy (autopsy), gross examination only; stillborn or newborn with brain         | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88016          | Necropsy (autopsy), gross examination only; macerated stillborn                     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88020          | Necropsy (autopsy), gross and microscopic; without CNS                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 88025          | Necropsy (autopsy), gross and microscopic; with brain                               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 88027          | Necropsy (autopsy), gross and microscopic; with brain and spinal cord      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88028          | Necropsy (autopsy), gross and microscopic; infant with brain               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88029          | Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88036          | Necropsy (autopsy), limited, gross and/or microscopic; regional            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88037          | Necropsy (autopsy), limited, gross and/or microscopic; single organ        | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88040          | Necropsy (autopsy); forensic examination                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88045          | Necropsy (autopsy); coroner's call   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 88099          | Unlisted necropsy (autopsy) procedure                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 89258          | Cryopreservation; embryo(s)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| 89259          | Cryopreservation; sperm  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| 89335          | Cryopreservation, reproductive tissue, testicular                          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 89337          | Cryopreservation, mature oocyte(s)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2019       | 12/31/2999  |
| 89342          | Storage (per year); embryo(s)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |
| 89343          | Storage (per year); sperm/semen  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |
| 89344          | Storage (per year); reproductive tissue, testicular/ovarian  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 89346          | Storage (per year); oocyte(s)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |
| 89352          | Thawing of cryopreserved; embryo(s)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |
| 89353          | Thawing of cryopreserved; sperm/semen, each aliquot  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018      | 12/31/2999  |
| 89354          | Thawing of cryopreserved; reproductive tissue, testicular/ovarian  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 89356          | Thawing of cryopreserved; oocytes, each aliquot  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 90589          | Chikungunya virus vaccine, live attenuated, for intramuscular use  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 8/22/2025      | 12/31/2999  |
| 90666          | Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2010       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 90667          | Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 7/1/2010       | 12/31/2999  |
| 90668          | Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 7/1/2010       | 12/31/2999  |
| 90867          | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 90868          | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 90869          | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| 90885          | Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes                       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| 90889          | Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| 92065          | Orthoptic training; performed by a physician or other qualified health care professional  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 11/1/2013      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 92622          | Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 92623          | Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 92972          | Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 3/31/2026   |
| 93228          | External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 93229          | External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2020       | 12/31/2999  |
| 93580          | Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2005       | 12/31/2999  |
| 93660          | Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 93702          | Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| 94452          | High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 94453          | High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| 95961          | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024       | 12/31/2999  |
| 95962          | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024       | 12/31/2999  |
| 95965          | Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| 95966          | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| 95967          | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 95981          | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008       | 12/31/2999  |
| 95982          | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008       | 12/31/2999  |
| 96000          | Comprehensive computer-based motion analysis by video-taping and 3D kinematics;  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010      | 12/31/2999  |
| 96001          | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010      | 12/31/2999  |
| 96002          | Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 96004          | Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010      | 12/31/2999  |
| 96547          | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 96548          | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 96571          | Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| 96912          | Photochemotherapy; psoralens and ultraviolet A (PUVA)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2009      | 12/31/2999  |
| 96913          | Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2010       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 97037          | Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| 97545          | Work hardening/conditioning; initial 2 hours  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024       | 12/31/2999  |
| 97546          | Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024       | 12/31/2999  |
| 97810          | Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| 97811          | Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| 97813          | Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| 97814          | Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 99026          | Hospital mandated on call service; in-hospital, each hour   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99027          | Hospital mandated on call service; out-of-hospital, each hour   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99071          | Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99075          | Medical testimony   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99080          | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form                                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99082          | Unusual travel (eg, transportation and escort of patient)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99175          | Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99360          | Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 99450          | Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates.   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99455          | Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99456          | Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| 99509          | Home visit for assistance with activities of daily living and personal care  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0054T          | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2025      | 12/31/2999  |
| 0055T          | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2025      | 12/31/2999  |
| 0071T          | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023      | 12/31/2999  |
| 0072T          | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023      | 12/31/2999  |
| 0105U          | Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0238T          | Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 0253T          | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011       | 12/31/2999  |
| 0308T          | Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2012       | 12/31/2999  |
| 0331T          | Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021       | 12/31/2999  |
| 0332T          | Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0338T          | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| 0339T          | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| 0342T          | Therapeutic apheresis with selective HDL delipidation and plasma reinfusion   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2025       | 12/31/2999  |
| 0345T          | Transcatheter mitral valve repair percutaneous approach via the coronary sinus  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016      | 12/31/2999  |
| 0402T          | Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0407U          | Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported as risk for progressive decline in kidney function | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| 0408T          | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0409T          | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0410T          | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0411T          | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0412T          | Removal of permanent cardiac contractility modulation system; pulse generator only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0413T          | Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0414T          | Removal and replacement of permanent cardiac contractility modulation system pulse generator only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0415T          | Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0416T          | Relocation of skin pocket for implanted cardiac contractility modulation pulse generator  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0417T          | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 0418T          | Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| 0449T          | Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2020       | 12/31/2999  |
| 0450T          | Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2021       | 12/31/2999  |
| 0474T          | Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2017       | 12/31/2999  |
| 0484T          | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0505T          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| 0516T          | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019      | 12/31/2999  |
| 0517T          | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019      | 12/31/2999  |
| 0529T          | Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019      | 12/31/2999  |
| 0544T          | Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0552T          | Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2020     | 12/31/2999  |
| 0561T          | Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2024      | 12/31/2999  |
| 0562T          | Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2024      | 12/31/2999  |
| 0569T          | Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2025     | 12/31/2999  |
| 0570T          | Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2025     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0571T          | Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0572T          | Insertion of substernal implantable defibrillator electrode   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0573T          | Removal of substernal implantable defibrillator electrode   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0574T          | Repositioning of previously implanted substernal implantable defibrillator-pacing electrode   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0575T          | Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0576T          | Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0577T          | Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0578T          | Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0579T          | Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0580T          | Removal of substernal implantable defibrillator pulse generator only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0584T          | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 0585T          | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |
| 0586T          | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |
| 0587T          | Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 6/14/2026   |
| 0588T          | Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 6/14/2026   |
| 0589T          | Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0590T          | Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 6/14/2026   |
| 0596T          | Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023     | 12/31/2999  |
| 0597T          | Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023     | 12/31/2999  |
| 0600T          | Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023       | 12/31/2999  |
| 0601T          | Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0614T          | Removal and replacement of substernal implantable defibrillator pulse generator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| 0646T          | Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2025     | 12/31/2999  |
| 0650T          | Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021       | 12/31/2999  |
| 0655T          | Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 6/14/2026   |
| 0692T          | Therapeutic ultrafiltration   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024       | 12/31/2999  |
| 0740T          | Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0741T          | Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023       | 12/31/2999  |
| 0784T          | Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 0785T          | Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 0786T          | Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 0787T          | Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0796T          | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0797T          | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0798T          | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0799T          | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0800T          | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0801T          | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0802T          | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0803T          | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| 0804T          | Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0810T          | Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| 0811T          | Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2024       | 12/31/2999  |
| 0812T          | Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2024       | 12/31/2999  |
| 0823T          | Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024      | 12/31/2999  |
| 0824T          | Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 0825T          | Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024      | 12/31/2999  |
| 0826T          | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024      | 12/31/2999  |
| 0861T          | Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 0862T          | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| 0863T          | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| 0947T          | Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 12/31/2999  |
| 0963T          | Anoscopy with directed submucosal injection of bulking agent into anal canal   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| 1019T          | Lymphovenous bypass, including robotic assistance, when performed, per extremity   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 12/31/2999  |
| 9701A          | Non-prescription Drugs   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A0021          | Ambulance service, outside state per mile, transport (medicaid only)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| A0080          | Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |
| A0090          | Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A0100          | Non-emergency transportation; taxi  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0110          | Non-emergency transportation and bus, intra or inter state carrier                                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0120          | Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0130          | Non-emergency transportation: wheel-chair van   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0140          | Non-emergency transportation and air travel (private or commercial) intra or inter state          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0160          | Non-emergency transportation: per mile - case worker or social worker                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0170          | Transportation ancillary: parking fees, tolls, other  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0180          | Non-emergency transportation: ancillary: lodging-recipient  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0190          | Non-emergency transportation: ancillary: meals-recipient  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0200          | Non-emergency transportation: ancillary: lodging escort   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |
| A0210          | Non-emergency transportation: ancillary: meals-escort   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A0426          | Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/15/2014      | 12/31/2999  |
| A0431          | Ambulance service, conventional air services, transport, one way (rotary wing)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/15/2007     | 12/31/2999  |
| A0436          | Rotary wing air mileage, per statute mile  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| A0888          | Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |
| A0999          | Unlisted ambulance service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A4100          | Non-sheet form skin substitute, fda cleared as a device, not otherwise specified (list in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2022       | 12/31/2999  |
| A4244          | Alcohol or peroxide, per pint  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A4246          | Betadine or phiso hex solution, per pint   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4247          | Betadine or iodine swabs/wipes, per box  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4335          | Incontinence supply; miscellaneous   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A4335          | Incontinence supply; miscellaneous   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4341          | Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/15/2023     | 12/31/2999  |
| A4342          | Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/15/2023     | 12/31/2999  |
| A4421          | Ostomy supply; miscellaneous   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A4450          | Tape, non-waterproof, per 18 square inches   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| A4452          | Tape, waterproof, per 18 square inches   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4458          | Enema bag with tubing, reusable  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4465          | Non-elastic binder for extremity   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4490          | Surgical stockings above knee length, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4495          | Surgical stockings thigh length, each  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4500          | Surgical stockings below knee length, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4510          | Surgical stockings full length, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4520          | Incontinence garment, any type, (e.g., brief, diaper), each                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| A4540          | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| A4541          | Monthly supplies for use of device coded at e0733   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| A4545          | Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |
| A4554          | Disposable underpads, all sizes   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4555          | Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2017      | 12/31/2999  |
| A4558          | Conductive gel or paste, for use with electrical device (e.g., tens, nmes), per oz  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| A4638          | Replacement battery for patient-owned ear pulse generator, each   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024       | 12/31/2999  |
| A4639          | Replacement pad for infrared heating pad system, each   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2025      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A4641          | Radiopharmaceutical, diagnostic, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A4649          | Surgical supply; miscellaneous   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A4890          | Contracts, repair and maintenance, for hemodialysis equipment  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4913          | Miscellaneous dialysis supplies, not otherwise specified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A4927          | Gloves, non-sterile, per 100   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4931          | Oral thermometer, reusable, any type, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A4932          | Rectal thermometer, reusable, any type, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A5507          | For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A6216          | Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without adhesive border, each dressing   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A6217          | Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But less than or equal to 48 sq. In. , without adhesive border, each dressing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A6218          | Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In. , without adhesive border, each dressing                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A6261          | Wound filler, gel/paste, per fluid ounce, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A6262          | Wound filler, dry form, per gram, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A6512          | Compression burn garment, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A6519          | Gradient compression garment, not otherwise specified, for nighttime use, each   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2025       | 12/31/2999  |
| A6530          | Gradient compression stocking, below knee, 18-30 mmhg, each  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A6531          | Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6533          | Gradient compression stocking, thigh length, 18-30 mmhg, each                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6534          | Gradient compression stocking, thigh length, 30-40 mmhg, each                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6536          | Gradient compression stocking, full length/chap style, 18-30 mmhg, each                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6537          | Gradient compression stocking, full length/chap style, 30-40 mmhg, each                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6539          | Gradient compression stocking, waist length, 18-30 mmhg, each                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6540          | Gradient compression stocking, waist length, 30-40 mmhg, each                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6544          | Gradient compression stocking, garter belt   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A6549          | Gradient compression garment, not otherwise specified, for daytime use, each             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A6549          | Gradient compression garment, not otherwise specified, for daytime use, each             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A9150          | Non-prescription drugs   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A9152          | Single vitamin/mineral/trace element, oral, per dose, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005       | 12/31/2999  |
| A9152          | Single vitamin/mineral/trace element, oral, per dose, not otherwise specified  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| A9153          | Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005       | 12/31/2999  |
| A9153          | Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| A9270          | Non-covered item or service  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A9273          | Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2011       | 12/31/2999  |
| A9279          | Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2007       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A9280          | Alert or alarm device, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A9282          | Wig, any type, each  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| A9291          | Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2024       | 12/31/2999  |
| A9300          | Exercise equipment   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| A9579          | Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (nos), per ml                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| A9597          | Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017       | 12/31/2999  |
| A9598          | Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A9698          | Non-radioactive contrast imaging material, not otherwise classified, per study                                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006       | 12/31/2999  |
| A9699          | Radiopharmaceutical, therapeutic, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| A9900          | Miscellaneous dme supply, accessory, and/or service component of another hcpcs code                             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| A9999          | Miscellaneous dme supply or accessory, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| B4102          | Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| B4103          | Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| B4104          | Additive for enteral formula (e.g., fiber)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| B4105          | In-line cartridge containing digestive enzyme(s) for enteral feeding, each  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019      | 12/31/2999  |
| B4149          | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |
| B4150          | Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| B4152          | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| B4154          | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2013       | 12/31/2999  |
| B4158          | Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2005       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| B4159          | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit                                    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| B4160          | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| B4164          | Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| B9998          | Noc for enteral supplies  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/16/2015      | 12/31/2999  |
| B9999          | Noc for parenteral supplies   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| C1062          | Intravertebral body fracture augmentation with implant (e.g., metal, polymer)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| C1605          | Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024       | 12/31/2999  |
| C1735          | Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| C1736          | Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2025     | 12/31/2999  |
| C1737          | Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2025       | 12/31/2999  |
| C1761          | Catheter, transluminal intravascular lithotripsy, coronary  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021       | 3/31/2026   |
| C1764          | Event recorder, cardiac (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| C1776          | Joint device (implantable)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017       | 12/31/2999  |
| C1778          | Lead, neurostimulator (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| C1783          | Ocular implant, aqueous drainage assist device  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2015      | 12/31/2999  |
| C1817          | Septal defect implant system, intracardiac  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2014      | 12/31/2999  |
| C1818          | Integrated keratoprosthesis   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015       | 12/31/2999  |
| C1820          | Generator, neurostimulator (implantable), with rechargeable battery and charging system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| C1821          | Interspinous process distraction device (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2025      | 12/31/2999  |
| C1822          | Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |
| C1824          | Generator, cardiac contractility modulation (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 6/14/2026   |
| C1825          | Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2021       | 12/31/2999  |
| C1826          | Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| C1833          | Monitor, cardiac, including intracardiac lead and all system components (implantable)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| C1889          | Implantable/insertable device, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2017       | 12/31/2999  |
| C2624          | Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/16/2019      | 12/31/2999  |
| C2698          | Brachytherapy source, stranded, not otherwise specified, per source   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| C2699          | Brachytherapy source, non-stranded, not otherwise specified, per source   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| C7531          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| C7534          | 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                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| C7535          | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| C7537          | Insertion of new or replacement of permanent pacemaker with atrial transvenous electrode(s), with 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)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| C7538          | Insertion of new or replacement of permanent pacemaker with ventricular transvenous electrode(s), with 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)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| C7539          | Insertion of new or replacement of permanent pacemaker with atrial and ventricular transvenous electrode(s), with 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)    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| C7540          | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator, dual lead system, with 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2026       | 12/31/2999  |
| C8007          | Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| C8008          | Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| C8009          | Removal of hypoglossal nerve neurostimulator array and pulse generator  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| C8010          | Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2026       | 12/31/2999  |
| C8011          | Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| C8012          | Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| C8013          | Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| C9309          | Injection, onasemnogene abeparvovec-brve, per treatment  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2026       | 12/31/2999  |
| C9399          | unclassified drugs or biologicals  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2012       | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| C9767          | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021      | 12/31/2999  |
| C9782          | Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024       | 12/31/2999  |
| C9785          | Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| C9793          | 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| D2999          | unspecified restorative procedure, by report             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D3410          | apicoectomy - anterior                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D3999          | unspecified endodontic procedure, by report              | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D4999          | unspecified periodontal procedure, by report             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D5899          | unspecified removable prosthodontic procedure, by report | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D5999          | unspecified maxillofacial prosthesis, by report          | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D6199          | unspecified implant procedure, by report                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| D6999          | unspecified fixed prosthodontic procedure, by report  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D7210          | extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D7220          | removal of impacted tooth - soft tissue   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D7230          | removal of impacted tooth - partially bony  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D7999          | unspecified oral surgery procedure, by report   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| D8210          | removable appliance therapy   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D8220          | fixed appliance therapy   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| D8999          | unspecified orthodontic procedure, by report  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| D9999          | unspecified adjunctive procedure, by report  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| E0152          | Walker, battery powered, wheeled, folding, adjustable or fixed height                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/15/2025      | 12/31/2999  |
| E0162          | Sitz bath chair  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E0183          | Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2022      | 12/31/2999  |
| E0187          | Water pressure mattress  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| E0190          | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 2/1/2010       | 12/31/2999  |
| E0201          | Penile contracture device, manual, greater than 3 lbs traction force                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/15/2025      | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E0210          | Electric heat pad, standard                         | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0215          | Electric heat pad, moist                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0217          | Water circulating heat pad with pump                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 6/1/2006       | 12/31/2999  |
| E0218          | Fluid circulating cold pad with pump, any type      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |
| E0221          | Infrared heating pad system                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2025      | 12/31/2999  |
| E0236          | Pump for water circulating pad                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |
| E0240          | Bath/shower chair, with or without wheels, any size | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0241          | Bath tub wall rail, each                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0242          | Bath tub rail, floor base                           | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0243          | Toilet rail, each                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E0244          | Raised toilet seat  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0245          | Tub stool or bench  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0246          | Transfer tub rail attachment  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0247          | Transfer bench for tub or toilet with or without commode opening              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0248          | Transfer bench, heavy duty, for tub or toilet with or without commode opening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0249          | Pad for water circulating heat unit, for replacement only                     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 9/1/2006       | 12/31/2999  |
| E0273          | Bed board   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |
| E0274          | Over-bed table  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2021       | 12/31/2999  |
| E0280          | Bed cradle, any type  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E0291          | Hospital bed, fixed height, without side rails, without mattress   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/15/2014      | 12/31/2999  |
| E0293          | Hospital bed, variable height, hi-lo, without side rails, without mattress   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/15/2014      | 12/31/2999  |
| E0315          | Bed accessory: board, table, or support device, any type   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |
| E0316          | Safety enclosure frame/canopy for use with hospital bed, any type  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |
| E0446          | Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| E0462          | Rocking bed with or without side rails   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E0492          | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2024       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| E0493          | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2024       | 12/31/2999  |
| E0530          | Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2024       | 12/31/2999  |
| E0616          | Implantable cardiac event recorder with memory, activator and programmer  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| E0620          | Skin piercing device for collection of capillary blood, laser, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E0625          | Patient lift, bathroom or toilet, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 12/21/2004     | 12/31/2999  |
| E0652          | Pneumatic compressor, segmental home model with calibrated gradient pressure  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2006       | 12/31/2999  |
| E0656          | Segmental pneumatic appliance for use with pneumatic compressor, trunk  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| E0658          | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| E0659          | Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| E0667          | Segmental pneumatic appliance for use with pneumatic compressor, full leg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2025       | 12/31/2999  |
| E0675          | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| E0676          | Intermittent limb compression device (includes all accessories), not otherwise specified  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2007       | 12/31/2999  |
| E0676          | Intermittent limb compression device (includes all accessories), not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 3/20/2019      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E0677          | Non-pneumatic sequential compression garment, trunk                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023       | 12/31/2999  |
| E0678          | Non-pneumatic sequential compression garment, full leg                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0679          | Non-pneumatic sequential compression garment, half leg                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0680          | Non-pneumatic compression controller with sequential calibrated gradient pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0681          | Non-pneumatic compression controller without calibrated gradient pressure         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0682          | Non-pneumatic sequential compression garment, full arm                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E0683          | Non-pneumatic, non-sequential, peristaltic wave compression pump                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 12/31/2999  |
| E0692          | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2006       | 12/31/2999  |
| E0700          | Safety equipment, device or accessory, any type  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| E0733          | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0735          | Non-invasive vagus nerve stimulator  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| E0736          | Transcutaneous tibial nerve stimulator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024       | 6/14/2026   |
| E0737          | Transcutaneous tibial nerve stimulator, controlled by phone application                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 6/14/2026   |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E0766          | Electrical stimulation device used for cancer treatment, includes all accessories, any type  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/15/2017      | 12/31/2999  |
| E0769          | Electrical stimulation or electromagnetic wound treatment device, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005       | 12/31/2999  |
| E0770          | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2009       | 12/31/2999  |
| E0920          | Fracture frame, attached to bed, includes weights  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2005      | 12/31/2999  |
| E0930          | Fracture frame, free standing, includes weights  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2005      | 12/31/2999  |
| E0946          | Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2005      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E0948          | Fracture frame, attachments for complex cervical traction  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020       | 12/31/2999  |
| E0984          | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E0985          | Wheelchair accessory, seat lift mechanism  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E0986          | Manual wheelchair accessory, power assist system   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E0988          | Manual wheelchair accessory, lever-activated, wheel drive, pair  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E1005          | Wheelchair accessory, power seatng system, recline only, with power shear reduction                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E1006          | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E1008          | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction                                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E1009          | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E1010          | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E1012          | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016       | 12/31/2999  |
| E1022          | Wheelchair transportation securement system, any type includes all components and accessories   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E1023          | Wheelchair transit securement system, includes all components and accessories                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025       | 12/31/2999  |
| E1083          | Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E1085          | Hemi-wheelchair, fixed full length arms, swing away detachable foot rests                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E1087          | High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E1170          | Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E1171          | Amputee wheelchair, fixed full length arms, without footrests or legrest                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E1239          | Power wheelchair, pediatric size, not otherwise specified        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2014      | 12/31/2999  |
| E1239          | Power wheelchair, pediatric size, not otherwise specified        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2005       | 12/31/2999  |
| E1295          | Heavy duty wheelchair, fixed full length arms, elevating legrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| E1300          | Whirlpool, portable (overtub type)                               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E1301          | Whirlpool tub, walk-in, portable                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2024      | 12/31/2999  |
| E1310          | Whirlpool, non-portable (built-in type)                          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E1355          | Stand/rack   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E1399          | Durable medical equipment, miscellaneous                                       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/15/2015      | 12/31/2999  |
| E1699          | Dialysis equipment, not otherwise specified                                    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| E1700          | Jaw motion rehabilitation system   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E1701          | Replacement cushions for jaw motion rehabilitation system, pkg. Of 6           | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E1702          | Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| E2120          | Pulse generator system for tympanic treatment of inner ear endolymphatic fluid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2024       | 12/31/2999  |
| E2207          | Wheelchair accessory, crutch and cane holder, each                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 6/1/2006       | 12/31/2999  |
| E2216          | Manual wheelchair accessory, foam filled propulsion tire, any size, each       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E2295          | Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009       | 12/31/2999  |
| E2298          | Complex rehabilitative power wheelchair accessory, power seat elevation system, any type   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |
| E2301          | Wheelchair accessory, power standing system, any type  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020       | 12/31/2999  |
| E2310          | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2007      | 12/31/2999  |
| E2311          | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2007      | 12/31/2999  |
| E2312          | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E2313          | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008       | 12/31/2999  |
| E2321          | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E2322          | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2323          | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2324          | Power wheelchair accessory, chin cup for chin control interface   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2325          | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E2340          | Power wheelchair accessory, nonstandard seat frame width, 20-23 inches  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2341          | Power wheelchair accessory, nonstandard seat frame width, 24-27 inches  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2342          | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2343          | Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2351          | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2358          | Power wheelchair accessory, group 34 non-sealed lead acid battery, each   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| E2359          | Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012       | 12/31/2999  |
| E2360          | Power wheelchair accessory, 22 nf non-sealed lead acid battery, each                                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2361          | Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat)    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2362          | Power wheelchair accessory, group 24 non-sealed lead acid battery, each                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2363          | Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2364          | Power wheelchair accessory, u-1 non-sealed lead acid battery, each                                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E2365          | Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2366          | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2367          | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2371          | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each                             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2372          | Power wheelchair accessory, group 27 non-sealed lead acid battery, each  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| E2373          | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E2374          | Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E2375          | Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E2376          | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E2377          | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014      | 12/31/2999  |
| E2397          | Power wheelchair accessory, lithium-based battery, each  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008       | 12/31/2999  |
| E2500          | Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| E2502          | Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E2504          | Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E2506          | Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time                                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E2508          | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E2510          | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| E2511          | Speech generating software program, for personal computer or personal digital assistant  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E2512          | Accessory for speech generating device, mounting system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| E2513          | Accessory for speech generating device, electromyographic sensor   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2025      | 12/31/2999  |
| E2599          | Accessory for speech generating device, not otherwise classified   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| E2599          | Accessory for speech generating device, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| E2628          | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2014      | 12/31/2999  |
| E2629          | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2014      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| E2632          | Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2014      | 12/31/2999  |
| E2633          | Wheelchair accessory, addition to mobile arm support, supinator   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/15/2014      | 12/31/2999  |
| G0235          | Pet imaging, any site, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| G0260          | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2026      | 12/31/2999  |
| G0276          | Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2015       | 12/31/2999  |
| G0293          | Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| G0294          | Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| G0341          | Percutaneous islet cell transplant, includes portal vein catheterization and infusion   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| G0342          | Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| G0343          | Laparotomy for islet cell transplant, includes portal vein catheterization and infusion   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| G0429          | Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| G0681          | Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; first 25 sq cm or less of wound surface area   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2026       | 12/31/2999  |
| G0682          | Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| G0683          | Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2026       | 12/31/2999  |
| G0684          | Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2026       | 12/31/2999  |
| G2083          | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2021       | 12/31/2999  |
| G8395          | Left ventricular ejection fraction (lvef) >= 40% or documentation as normal or mildly depressed left ventricular systolic function   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2008       | 12/31/2999  |
| G8396          | Left ventricular ejection fraction (lvef) not performed or documented  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2008       | 12/31/2999  |
| G8397          | Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/2008       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| G8399          | Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8400          | Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8404          | Lower extremity neurological exam performed and documented   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8405          | Lower extremity neurological exam not performed  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8410          | Footwear evaluation performed and documented   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8415          | Footwear evaluation was not performed  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8416          | Clinician documented that patient was not an eligible candidate for footwear evaluation measure          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8417          | Bmi is documented above normal parameters and a follow-up plan is documented                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8418          | Bmi is documented below normal parameters and a follow-up plan is documented                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8419          | Bmi documented outside normal parameters, no follow-up plan documented, no reason given                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8420          | Bmi is documented within normal parameters and no follow-up plan is required                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| G8421          | Bmi not documented and no reason is given   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8427          | Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8428          | Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8430          | Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status)                                       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8431          | Screening for depression is documented as being positive and a follow-up plan is documented   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8432          | Depression screening not documented, reason not given   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8433          | Screening for depression not completed, documented patient or medical reason  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8450          | Beta-blocker therapy prescribed   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8451          | Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |

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|----------------|--|--|----------------|-------------|
| G8452          | Beta-blocker therapy not prescribed  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8465          | High or very high risk of recurrence of prostate cancer  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8473          | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy prescribed   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8474          | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8475          | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8476          | Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8477          | Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8478          | Blood pressure measurement not performed or documented, reason not given   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| G8559          | Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
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| G8560          | Patient has a history of active drainage from the ear within the previous 90 days  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8561          | Patient is not eligible for the referral for otologic evaluation for patients with a history of active drainage measure                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8562          | Patient does not have a history of active drainage from the ear within the previous 90 days  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8563          | Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8564          | Patient was referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8565          | Verification and documentation of sudden or rapidly progressive hearing loss   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8566          | Patient is not eligible for the referral for otologic evaluation for sudden or rapidly progressive hearing loss measure                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8567          | Patient does not have verification and documentation of sudden or rapidly progressive hearing loss   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8568          | Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8569          | Prolonged postoperative intubation (> 24 hrs) required   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8570          | Prolonged postoperative intubation (> 24 hrs) not required   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
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| G8575          | Developed postoperative renal failure or required dialysis   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8576          | No postoperative renal failure/dialysis not required   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8577          | Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason                    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8578          | Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8598          | Aspirin or another antiplatelet therapy used   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8599          | Aspirin or another antiplatelet therapy not used, reason not given   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8600          | Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8601          | Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |
| G8602          | Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
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| G9012          | Other specified case management service not elsewhere classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| G9050          | Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9051          | Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9052          | Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9053          | Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| G9054          | Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9055          | Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| G9055          | Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9056          | Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9057          | Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| G9058          | Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |

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|----------------|--|--|----------------|-------------|
| G9059          | Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9060          | Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9061          | Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9062          | Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9063          | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage i (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9064          | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage ii (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| G9065          | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9066          | Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9067          | Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9068          | Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9069          | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9070          | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| G9071          | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9072          | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9073          | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iia-iib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9074          | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iia-iib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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

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|----------------|---|--|----------------|-------------|
| G9084          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9085          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9086          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9087          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9088          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| G9089          | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9090          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9091          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9092          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9093          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| G9094          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9095          | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9096          | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9097          | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9098          | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| G9099          | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)                                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9100          | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9101          | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9102          | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9103          | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| G9104          | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9105          | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9106          | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9107          | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9108          | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9109          | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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|----------------|--|--|----------------|-------------|
| G9110          | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9111          | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9112          | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9113          | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9114          | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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| G9115          | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9116          | Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9117          | Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9123          | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9124          | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9125          | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |

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| G9126          | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9129          | Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9130          | Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006       | 12/31/2999  |
| G9131          | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9132          | Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-refractory/androgen-independent (e.g., rising psa on anti-androgen therapy or post-orchietomy); clinical metastases (for use in a medicare-approved demonstration project)           | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9133          | Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-responsive; clinical metastases or m1 at diagnosis (for use in a medicare-approved demonstration project)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9134          | Oncology; disease status; non-hodgkin's lymphoma, any cellular classification; stage i, ii at diagnosis, not relapsed, not refractory (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |

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| G9135          | Oncology; disease status; non-hodgkin's lymphoma, any cellular classification; stage iii, iv, not relapsed, not refractory (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9136          | Oncology; disease status; non-hodgkin's lymphoma, transformed from original cellular diagnosis to a second cellular classification (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9137          | Oncology; disease status; non-hodgkin's lymphoma, any cellular classification; relapsed/refractory (for use in a medicare-approved demonstration project)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9138          | Oncology; disease status; non-hodgkin's lymphoma, any cellular classification; diagnostic evaluation, stage not determined, evaluation of possible relapse or non-response to therapy, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |
| G9139          | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; extent of disease unknown, staging in progress, not listed (for use in a medicare-approved demonstration project)              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| G9140          | Frontier extended stay clinic demonstration; for a patient stay in a clinic approved for the cms demonstration project; the following measures should be present: the stay must be equal to or greater than 4 hours; weather or other conditions must prevent transfer or the case falls into a category of monitoring and observation cases that are permitted by the rules of the demonstration; there is a maximum frontier extended stay clinic (fesc) visit of 48 hours, except in the case when weather or other conditions prevent transfer; payment is made on each period up to 4 hours, after the first 4 hours | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008       | 12/31/2999  |
| H0021          | Alcohol and/or drug training service (for staff and personnel not employed by providers)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H0026          | Alcohol and/or drug prevention process service, community-based (delivery of services to develop skills of impactors)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H0027          | Alcohol and/or drug prevention environmental service (broad range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H0028          | Alcohol and/or drug prevention problem identification and referral service (e. G. Student assistance and employee assistance programs), does not include assessment   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H0029          | Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use e. G. Alcohol free social events)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H0030          | Behavioral health hotline service   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| H0041          | Foster care, child, non-therapeutic, per diem                     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H0042          | Foster care, child, non-therapeutic, per month                    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H0043          | Supported housing, per diem                                       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H0044          | Supported housing, per month                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H0045          | Respite care services, not in the home, per diem                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H0046          | Mental health services, not otherwise specified                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| H0047          | Alcohol and/or other drug abuse services, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| H1010          | Non-medical family planning education, per session                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| H2017          | Psychosocial rehabilitation services, per 15 minutes              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| H2018          | Psychosocial rehabilitation services, per diem             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2023          | Supported employment, per 15 minutes                       | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2024          | Supported employment, per diem                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2025          | Ongoing support to maintain employment, per 15 minutes     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2026          | Ongoing support to maintain employment, per diem           | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2028          | Sexual offender treatment service, per 15 minutes          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2029          | Sexual offender treatment service, per diem                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2030          | Mental health clubhouse services, per 15 minutes           | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2031          | Mental health clubhouse services, per diem                 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| H2034          | Alcohol and/or drug abuse halfway house services, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| J0013          | Esketamine, nasal spray, 1 mg                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2026       | 12/31/2999  |
| J0174          | Lecanemab-irmb, for intravenous injection, 1 mg               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/15/2023      | 12/31/2999  |
| J0218          | Injection, olipudase alfa-rpcp, 1 mg                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2023       | 12/31/2999  |
| J0219          | Injection, avalglucosidase alfa-ngpt, 4 mg                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2022       | 12/31/2999  |
| J0220          | Injection, alglucosidase alfa, 10 mg, not otherwise specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2008       | 12/31/2999  |
| J0220          | Injection, alglucosidase alfa, 10 mg, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| J0222          | Injection, Patisiran, 0.1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2021       | 12/31/2999  |
| J0248          | Injection, remdesivir, 1mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2024       | 12/31/2999  |
| J0256          | Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J0485          | Injection, belatacept, 1 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2024       | 12/31/2999  |
| J0491          | Injection, anifrolumab-fnia, 1 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2022       | 12/31/2999  |
| J0517          | Injection, benralizumab, 1 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2019       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| J0585          | Injection, onabotulinumtoxina, 1 unit                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| J0589          | Injection, daxibotulinumtoxina-lanm, 1 unit             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024      | 12/31/2999  |
| J0600          | Injection, edetate calcium disodium, up to 1000 mg      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| J0791          | Injection, crizanlizumab-tmca, 5 mg                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 12/31/2999  |
| J0888          | Injectin, epoetin beta, 1 microgram, (for non esrd use) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015       | 12/31/2999  |
| J1203          | Injection, cipaglusosidase alfa-atga, 5 mg              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024      | 12/31/2999  |

| Procedure Code | Code Description                   | Code Group & Description  | Effective Date | Ending Date |
|----------------|------------------------------------|---|----------------|-------------|
| J1301          | Injection, edaravone, 1 mg         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |
| J1302          | Injection, sutimlimab-jome, 10 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022      | 12/31/2999  |
| J1303          | Injection, ravulizumab-cwvz, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2020      | 12/31/2999  |
| J1304          | Injection, tofersen, 1 mg          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| J1305          | Injection, evinacumab-dgnb, 5mg    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021      | 12/31/2999  |
| J1306          | Injection, inclisiran, 1 mg        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| J1307          | Injection, crovalimab-akkz, 10 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2025      | 12/31/2999  |
| J1411          | Injection, etranacogene dezaparvovec-drlb, per therapeutic dose  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023       | 12/31/2999  |
| J1412          | Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10 <sup>13</sup> vector genomes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| J1413          | Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| J1426          | Injection, casimersen, 10 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021      | 12/31/2999  |
| J1427          | Injection, viltolarsen, 10 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2021       | 12/31/2999  |

| Procedure Code | Code Description                               | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| J1428          | Injection, eteplirsen, 10 mg                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018       | 12/31/2999  |
| J1429          | Injection, golodirsen, 10 mg                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020      | 12/31/2999  |
| J1440          | Fecal microbiota, live - jslm, 1 ml            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024       | 12/31/2999  |
| J1551          | Injection, immune globulin (cutaquist), 100 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022       | 12/31/2999  |
| J1553          | Injection, immune globulin (yimmugo), 100 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2026       | 12/31/2999  |
| J1554          | Injection, immune globulin (asceniv), 500 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| J1566          | Injection, immune globulin, intravenous, lyophilized (e. G. Powder), not otherwise specified, 500 mg     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J1576          | Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2023       | 12/31/2999  |
| J1599          | Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J1628          | Injection, guselkumab, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2025       | 12/31/2999  |
| J1726          | Injection, hydroxyprogesterone caproate, (makena), 10 mg   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 7/15/2023      | 12/31/2999  |
| J1729          | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg                                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J1729          | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg                                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 7/15/2023      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| J1747          | Injection, spesolimab-sbzo, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023       | 12/31/2999  |
| J1823          | Injection, inebilizumab-cdon, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021       | 12/31/2999  |
| J1930          | Injection, lanreotide, 1 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |
| J2267          | Injection, mirikizumab-mrkz, 1 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024       | 12/31/2999  |
| J2353          | Injection, octreotide, depot form for intramuscular injection, 1 mg                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |
| J2354          | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| J2356          | Injection, tezepelumab-ekko, 1 mg                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022       | 12/31/2999  |
| J2508          | Injection, pegunigalsidase alfa-iwxj, 1 mg               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| J2782          | Injection, avacincaptad pegol, 0.1 mg                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024      | 12/31/2999  |
| J2787          | Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020       | 12/31/2999  |
| J3032          | Injection, eptinezumab-jjmr, 1 mg                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| J3111          | Injection, romosozumab-aqqg, 1 mg                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |

| Procedure Code | Code Description                                     | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| J3241          | Injection, teprotumumab-trbw, 10 mg                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020      | 12/31/2999  |
| J3247          | Injection, secukinumab, intravenous, 1 mg            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2024      | 12/31/2999  |
| J3299          | Injection, triamcinolone acetonide (xipere), 1 mg    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2022      | 12/31/2999  |
| J3393          | Injection, betibeglogene autotemcel, per treatment   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024       | 12/31/2999  |
| J3394          | Injection, lovitibeglogene autotemcel, per treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024       | 12/31/2999  |
| J3396          | Injection, verteporfin, 0.1 mg                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| J3398          | Injection, voretigene neparvovec-rzyl, 1 billion vector genomes   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2019       | 12/31/2999  |
| J3399          | Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10 <sup>15</sup> vector genomes                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2020       | 12/31/2999  |
| J3401          | Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 <sup>9</sup> pfu/ml vector genomes, per 0.1 ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/15/2024      | 12/31/2999  |
| J3404          | Injection, zopapogene imadenovec-drba suspension, per therapeutic dose  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2026       | 12/31/2999  |
| J3490          | Unclassified drugs  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| J3520          | Edetate disodium, per 150 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| J3570          | Laetrile, amygdalin, vitamin b17  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 6/1/2015       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| J3590          | Unclassified biologics  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| J3591          | Unclassified drug or biological used for esrd on dialysis                                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2019       | 12/31/2999  |
| J7183          | Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2024       | 12/31/2999  |
| J7192          | Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J7195          | Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| J7199          | Hemophilia clotting factor, not otherwise classified                                      | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| J7311          | Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/15/2011      | 12/31/2999  |
| J7313          | Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2016       | 12/31/2999  |
| J7351          | Injection, bimatoprost, intracameral implant, 1 microgram                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2020      | 12/31/2999  |
| J7355          | Injection, travoprost, intracameral implant, 1 microgram                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2024       | 12/31/2999  |
| J7599          | Immunosuppressive drug, not otherwise classified                            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| J7699          | Noc drugs, inhalation solution administered through dme                     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| J7799          | Noc drugs, other than inhalation drugs, administered through dme | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| J7999          | Compounded drug, not otherwise classified                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2016       | 12/31/2999  |
| J8498          | Antiemetic drug, rectal/suppository, not otherwise specified     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006       | 12/31/2999  |
| J8499          | Prescription drug, oral, non chemotherapeutic, nos               | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| J8597          | Antiemetic drug, oral, not otherwise specified                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2006       | 12/31/2999  |
| J8999          | Prescription drug, oral, chemotherapeutic, nos                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| J9029          | Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023       | 12/31/2999  |
| J9057          | Injection, copanlisib, 1 mg  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 4/1/2024       | 12/31/2999  |
| J9285          | Injection, olaratumab, 10 mg   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 9/1/2019       | 12/31/2999  |
| J9313          | Injection, moxetumomab pasudotox-tdfk, 0.01 mg                                 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 4/1/2024       | 12/31/2999  |
| J9332          | Injection, efgartigimod alfa-fcab, 2mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022       | 12/31/2999  |
| J9333          | Injection, rozanolixizumab-noli, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |
| J9334          | Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| J9376          | Injection, pozelimab-bbfg, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/15/2024      | 12/31/2999  |
| J9600          | Injection, porfimer sodium, 75 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2006       | 12/31/2999  |
| J9999          | Not otherwise classified, antineoplastic drugs   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| K0010          | Standard - weight frame motorized/power wheelchair   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| K0011          | Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| K0014          | Other motorized/power wheelchair base  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| K0108          | Wheelchair component or accessory, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 2/9/2017       | 12/31/2999  |
| K0746          | Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/1/2011       | 12/31/2999  |
| K0800          | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0801          | Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds                             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0802          | Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0806          | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| K0807          | Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0808          | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds                                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0812          | Power operated vehicle, not otherwise classified  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0812          | Power operated vehicle, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 2/9/2017       | 12/31/2999  |
| K0813          | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0814          | Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| K0815          | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0816          | Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0820          | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0821          | Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0822          | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0823          | Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds                  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| K0824          | Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0825          | Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0826          | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0827          | Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0828          | Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0829          | Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| K0830          | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0831          | Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0835          | Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0836          | Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0837          | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0838          | Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| K0839          | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0840          | Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0841          | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0842          | Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0843          | Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0848          | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| K0849          | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0850          | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0851          | Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0852          | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0853          | Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0854          | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| K0855          | Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0856          | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0857          | Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0858          | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0859          | Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0860          | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| K0861          | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0862          | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0863          | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0864          | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0868          | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0869          | Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| K0870          | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0871          | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0877          | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0878          | Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0879          | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |
| K0880          | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| K0884          | Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0885          | Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0886          | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0890          | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0891          | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K0898          | Power wheelchair, not otherwise classified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/1/2006      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| K0899          | Power mobile device; no dme pdac  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2006      | 12/31/2999  |
| K1030          | External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2022       | 6/14/2026   |
| L0999          | Addition to spinal orthosis, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| L1499          | Spinal orthosis, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L1834          | Knee orthosis, without knee joint, rigid, custom-fabricated   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| L1840          | Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| L1844          | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| L1846          | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| L2221          | Addition to lower extremity orthosis, ankle system, microprocessor-controlled feature plantarflexion and/or dorsiflexion, includes power source   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2026       | 12/31/2999  |
| L2999          | Lower extremity orthoses, not otherwise specified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L3040          | Foot, arch support, removable, premolded, longitudinal, each  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| L3050          | Foot, arch support, removable, premolded, metatarsal, each  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| L3060          | Foot, arch support, removable, premolded, longitudinal/metatarsal, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| L3649          | Orthopedic shoe, modification, addition or transfer, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L3999          | Upper limb orthosis, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L5610          | Addition to lower extremity, endoskeletal system, above knee, hydracadence system   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5611          | Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5613          | Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5614          | Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5615          | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| L5616          | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5620          | Addition to lower extremity, test socket, below knee   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5624          | Addition to lower extremity, test socket, above knee   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5629          | Addition to lower extremity, below knee, acrylic socket  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5631          | Addition to lower extremity, above knee or knee disarticulation, acrylic socket  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5638          | Addition to lower extremity, below knee, leather socket                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5639          | Addition to lower extremity, below knee, wood socket                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5640          | Addition to lower extremity, knee disarticulation, leather socket              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5642          | Addition to lower extremity, above knee, leather socket                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5644          | Addition to lower extremity, above knee, wood socket                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5645          | Addition to lower extremity, below knee, flexible inner socket, external frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5646          | Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5647          | Addition to lower extremity, below knee suction socket                                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5648          | Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5651          | Addition to lower extremity, above knee, flexible inner socket, external frame              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5652          | Addition to lower extremity, suction suspension, above knee or knee disarticulation socket  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5670          | Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5676          | Additions to lower extremity, below knee, knee joints, single axis, pair               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5704          | Custom shaped protective cover, below knee   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5705          | Custom shaped protective cover, above knee   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5706          | Custom shaped protective cover, knee disarticulation                                   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5710          | Addition, exoskeletal knee-shin system, single axis, manual lock                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5711          | Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5712          | Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5714          | Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5716          | Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock                          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5718          | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5722          | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5724          | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control                             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5726          | Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5728          | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5780          | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5785          | Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5790          | Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5795          | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5810          | Addition, endoskeletal knee-shin system, single axis, manual lock   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5811          | Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5812          | Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5814          | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5816          | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock                                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5818          | Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5822          | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5824          | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5826          | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5827          | Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025       | 12/31/2999  |
| L5828          | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5830          | Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5840          | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5841          | Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024       | 12/31/2999  |
| L5848          | Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5856          | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2007      | 12/31/2999  |
| L5858          | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2007      | 12/31/2999  |
| L5859          | Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L5926          | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| L5961          | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| L5962          | Addition, endoskeletal system, below knee, flexible protective outer surface covering system   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5964          | Addition, endoskeletal system, above knee, flexible protective outer surface covering system   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5966          | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5968          | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2015      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5969          | Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014       | 12/31/2999  |
| L5970          | All lower extremity prostheses, foot, external keel, sach foot  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5972          | All lower extremity prostheses, foot, flexible keel   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5973          | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019      | 12/31/2999  |
| L5974          | All lower extremity prostheses, foot, single axis ankle/foot  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5976          | All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L5978          | All lower extremity prostheses, foot, multiaxial ankle/foot                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5979          | All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5980          | All lower extremity prostheses, flex foot system  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5981          | All lower extremity prostheses, flex-walk system or equal                                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5982          | All exoskeletal lower extremity prostheses, axial rotation unit                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |
| L5984          | All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| L5985          | All endoskeletal lower extremity prostheses, dynamic prosthetic pylon  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5986          | All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5987          | All lower extremity prosthesis, shank foot system with vertical loading pylon  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 6/1/2006       | 12/31/2999  |
| L5999          | Lower extremity prosthesis, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L6026          | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2015       | 12/31/2999  |
| L6611          | Addition to upper extremity prosthesis, external powered, additional switch, any type  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2009       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L6621          | Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6700          | Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2025       | 12/31/2999  |
| L6880          | Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012       | 12/31/2999  |
| L6882          | Microprocessor control feature, addition to upper limb prosthetic terminal device   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6920          | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6925          | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L6930          | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6935          | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device                                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6940          | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6945          | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6950          | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L6955          | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L7008          | Electric hand, switch or myoelectric, controlled, pediatric                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7009          | Electric hook, switch or myoelectric controlled, adult                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7040          | Prehensile actuator, switch controlled   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7045          | Electric hook, switch or myoelectric controlled, pediatric                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7170          | Electronic elbow, hosmer or equal, switch controlled                             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7180          | Electronic elbow, microprocessor sequential control of elbow and terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L7181          | Electronic elbow, microprocessor simultaneous control of elbow and terminal device   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7185          | Electronic elbow, adolescent, variety village or equal, switch controlled            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7186          | Electronic elbow, child, variety village or equal, switch controlled                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7190          | Electronic elbow, adolescent, variety village or equal, myoelectronically controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7191          | Electronic elbow, child, variety village or equal, myoelectronically controlled      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7259          | Electronic wrist rotator, any type   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015       | 12/31/2999  |

| Procedure Code | Code Description                               | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| L7360          | Six volt battery, each                         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7362          | Battery charger, six volt, each                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7364          | Twelve volt battery, each                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7366          | Battery charger, twelve volt, each             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7367          | Lithium ion battery, rechargeable, replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009       | 12/31/2999  |
| L7368          | Lithium ion battery charger, replacement only  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| L7499          | Upper extremity prosthesis, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L8039          | Breast prosthesis, not otherwise specified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| L8048          | Unspecified maxillofacial prosthesis, by report, provided by a non-physician   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L8499          | Unlisted procedure for miscellaneous prosthetic services   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| L8604          | Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2009       | 12/31/2999  |
| L8606          | Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 5/1/2007       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L8607          | Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016       | 12/31/2999  |
| L8609          | Artificial cornea   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015       | 12/31/2999  |
| L8612          | Aqueous shunt   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2014       | 12/31/2999  |
| L8678          | Electrical stimulator supplies (external) for use with implantable neurostimulator, per month           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023      | 12/31/2999  |
| L8679          | Implantable neurostimulator, pulse generator, any type  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |
| L8680          | Implantable neurostimulator electrode, each   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L8681          | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023      | 12/31/2999  |
| L8682          | Implantable neurostimulator radiofrequency receiver   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/19/2022      | 12/31/2999  |
| L8683          | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023      | 12/31/2999  |
| L8685          | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |
| L8686          | Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |
| L8687          | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension                             | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| L8688          | Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2022       | 12/31/2999  |
| L8689          | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/15/2023      | 12/31/2999  |
| L8694          | Auditory osseointegrated device, transducer/actuator, replacement only, each                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2018       | 12/31/2999  |
| L8695          | External recharging system for battery (external) for use with implantable neurostimulator, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/19/2022      | 12/31/2999  |
| L8698          | Miscellaneous component, supply or accessory for use with total artificial heart system                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2019       | 12/31/2999  |
| L8699          | Prosthetic implant, not otherwise specified  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| L8701          | Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |
| L8702          | Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019       | 12/31/2999  |
| M0075          | Cellular therapy  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| M0100          | Intragastric hypothermia using gastric freezing   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| M0300          | Iv chelation therapy (chemical endarterectomy)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| M0301          | Fabric wrapping of abdominal aneurysm   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| P2029          | Congo red, blood  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.  | 1/1/1950       | 12/31/2999  |
| P2031          | Hair analysis (excluding arsenic)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q0490          | Emergency power source for use with electric ventricular assist device, replacement only                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2005      | 12/31/2999  |
| Q0492          | Emergency power supply cable for use with electric ventricular assist device, replacement only              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2005      | 12/31/2999  |
| Q0494          | Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2005      | 12/31/2999  |
| Q0502          | Mobility cart for pneumatic ventricular assist device, replacement only                                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2005      | 12/31/2999  |
| Q0504          | Power adapter for pneumatic ventricular assist device, replacement only, vehicle type                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2005      | 12/31/2999  |
| Q0507          | Miscellaneous supply or accessory for use with an external ventricular assist device                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q0508          | Miscellaneous supply or accessory for use with an implanted ventricular assist device   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013       | 12/31/2999  |
| Q0509          | Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under medicare part a | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 4/1/2013       | 12/31/2999  |
| Q0510          | Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| Q0511          | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30-day period      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| Q0512          | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2006       | 12/31/2999  |
| Q2026          | Injection, radiesse, 0.1 ml   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 8/15/2013      | 12/31/2999  |
| Q2028          | Injection, sculptra, 0.5 mg   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q2039          | Influenza virus vaccine, not otherwise specified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| Q2041          | Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2018       | 12/31/2999  |
| Q2042          | Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose                               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 7/1/2011       | 12/31/2999  |
| Q2049          | Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2024       | 12/31/2999  |
| Q2050          | Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| Q2052          | Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2014       | 12/31/2999  |
| Q2053          | Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2021       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| Q4101          | Apligraf, per square centimeter (add-on, list separately in addition to primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| Q4102          | Oasis wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| Q4105          | Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| Q4107          | Graftjacket, per square centimeter (add-on, list separately in addition to primary procedure)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| Q4108          | Integra matrix, per square centimeter (add-on, list separately in addition to primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |
| Q4114          | Integra flowable wound matrix, injectable, 1 cc  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020     | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| Q4137          | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024       | 12/31/2999  |
| Q4151          | Amnioband or guardian, per square centimeter (add-on, list separately in addition to primary procedure)                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021      | 12/31/2999  |
| Q4154          | Biovance, per square centimeter (add-on, list separately in addition to primary procedure)                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021      | 12/31/2999  |
| Q4159          | Affinity, per square centimeter (add-on, list separately in addition to primary procedure)                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2022       | 12/31/2999  |
| Q4160          | Nushield, per square centimeter (add-on, list separately in addition to primary procedure)                                 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2026       | 12/31/2999  |
| Q4168          | Amnioband, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| Q4186          | Epifix, per square centimeter (add-on, list separately in addition to primary procedure)                            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021      | 12/31/2999  |
| Q4187          | Epicord, per square centimeter (add-on, list separately in addition to primary procedure)                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021      | 12/31/2999  |
| Q4283          | Biovance tri-layer or biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023      | 12/31/2999  |
| Q4304          | Grafix plus, per square centimeter (add-on, list separately in addition to primary procedure)                       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024      | 12/31/2999  |
| Q4368          | Amchothick, per square centimeter (add-on, list separately in addition to primary procedure)                        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4369          | Amnioplast 3, per square centimeter (add-on, list separately in addition to primary procedure)                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| Q4370          | Aeroguard, per square centimeter (add-on, list separately in addition to primary procedure)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4371          | Neoguard, per square centimeter (add-on, list separately in addition to primary procedure)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4372          | Amchoplast excel, per square centimeter (add-on, list separately in addition to primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4373          | Membrane wrap lite, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4375          | Duograft ac, per square centimeter (add-on, list separately in addition to primary procedure)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4376          | Duograft aa, per square centimeter (add-on, list separately in addition to primary procedure)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| Q4377          | Trigraft ft, per square centimeter (add-on, list separately in addition to primary procedure)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4378          | Renew ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4379          | Amniodefend ft matrix, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4380          | Advograft one, per square centimeter (add-on, list separately in addition to primary procedure)         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4382          | Advograft dual, per square centimeter (add-on, list separately in addition to primary procedure)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4383          | Axolotl graft ultra, per square centimeter (add-on, list separately in addition to primary procedure)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| Q4384          | Axolotl dualgraft ultra, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4385          | Apollo ft, per square centimeter (add-on, list separately in addition to primary procedure)               | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4386          | Acesso trifaca, per square centimeter (add-on, list separately in addition to primary procedure)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4387          | Neothelium ft, per square centimeter (add-on, list separately in addition to primary procedure)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4388          | Neothelium 4l, per square centimeter (add-on, list separately in addition to primary procedure)           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4389          | Neothelium 4l+, per square centimeter (add-on, list separately in addition to primary procedure)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| Q4390          | Ascendion, per square centimeter (add-on, list separately in addition to primary procedure)         | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4391          | Amnioplast double, per square centimeter (add-on, list separately in addition to primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4392          | Grafix duo, per square centimeter (add-on, list separately in addition to primary procedure)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2026      | 12/31/2999  |
| Q4393          | Surgraft ac, per square centimeter (add-on, list separately in addition to primary procedure)       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4394          | Surgraft aca, per square centimeter (add-on, list separately in addition to primary procedure)      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |
| Q4395          | Acelagraft, per square centimeter (add-on, list separately in addition to primary procedure)        | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2026       | 6/14/2026   |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4396          | Natalin, per square centimeter (add-on, list separately in addition to primary procedure)          | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2026       | 6/14/2026   |
| Q4397          | Summit aaa, per square centimeter (add-on, list separately in addition to primary procedure)       | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 2/1/2026       | 6/14/2026   |
| Q4431          | Pma skin substitute product, not otherwise specified (list in addition to primary procedure)       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2026       | 12/31/2999  |
| Q4432          | 510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)    | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2026       | 12/31/2999  |
| Q4433          | 361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure) | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2026       | 12/31/2999  |
| Q5009          | Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/2007       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| Q5106          | Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2020      | 12/31/2999  |
| Q5133          | Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024       | 12/31/2999  |
| Q5134          | Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024       | 12/31/2999  |
| Q5135          | Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2025      | 12/31/2999  |
| Q5138          | Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg                | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024      | 12/31/2999  |
| Q9997          | Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg                           | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q9998          | Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2025       | 12/31/2999  |
| S0117          | Tretinoin, topical, 5 grams   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S0142          | Colistimethate sodium, inhalation solution administered through dme, concentrated form, per mg                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2005       | 12/31/2999  |
| S0197          | Prenatal vitamins, 30-day supply  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2005       | 12/31/2999  |
| S0207          | Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S0209          | Wheelchair van, mileage, per mile   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |
| S0215          | Non-emergency transportation; mileage, per mile   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| S0320          | Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S0590          | Integral lens service, miscellaneous services reported separately   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description  | Effective Date | Ending Date |
|----------------|---|---|----------------|-------------|
| S2140          | Cord blood harvesting for transplantation, allogeneic   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2013       | 12/31/2999  |
| S2142          | Cord blood-derived stem-cell transplantation, allogeneic  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2013       | 12/31/2999  |
| S2150          | Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950       | 12/31/2999  |
| S2202          | Echosclerotherapy   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012      | 12/31/2999  |
| S2400          | Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description  | Effective Date | Ending Date |
|----------------|--|---|----------------|-------------|
| S2401          | Repair, urinary tract obstruction in the fetus, procedure performed in utero                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023      | 12/31/2999  |
| S2402          | Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023      | 12/31/2999  |
| S2403          | Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero            | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2012      | 12/31/2999  |
| S2404          | Repair, myelomeningocele in the fetus, procedure performed in utero                              | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023      | 12/31/2999  |
| S2405          | Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero                     | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2012      | 12/31/2999  |
| S2409          | Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| S2409          | Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| S2411          | Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome                      | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 12/1/2022      | 12/31/2999  |
| S3600          | Stat laboratory request (situations other than s3601)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S3601          | Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S3900          | Surface electromyography (emg)   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/1/2025      | 12/31/2999  |
| S4015          | Complete in vitro fertilization cycle, not otherwise specified, case rate                        | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| S4024          | Air polymer-type a intrauterine foam, per study dose   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2025       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S4026          | Procurement of donor sperm from sperm bank                        | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4027          | Storage of previously frozen embryos                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4030          | Sperm procurement and cryopreservation services; initial visit    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4031          | Sperm procurement and cryopreservation services; subsequent visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4040          | Monitoring and storage of cryopreserved embryos, per 30 days      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4990          | Nicotine patches, legend  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4991          | Nicotine patches, non-legend                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S4995          | Smoking cessation gum   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5100          | Day care services, adult; per 15 minutes                          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5101          | Day care services, adult; per half day                            | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5102          | Day care services, adult; per diem                                | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S5105          | Day care services, center-based; services not included in program fee, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5108          | Home care training to home care client, per 15 minutes                          | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5109          | Home care training to home care client, per session                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5110          | Home care training, family; per 15 minutes                                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5111          | Home care training, family; per session   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5115          | Home care training, non-family; per 15 minutes                                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5116          | Home care training, non-family; per session                                     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5120          | Chore services; per 15 minutes  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5121          | Chore services; per diem  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5125          | Attendant care services; per 15 minutes   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S5126          | Attendant care services; per diem   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |

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

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S5146          | Foster care, therapeutic, child; per month  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5150          | Unskilled respite care, not hospice; per 15 minutes                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5151          | Unskilled respite care, not hospice; per diem   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5160          | Emergency response system; installation and testing                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5161          | Emergency response system; service fee, per month (excludes installation and testing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5162          | Emergency response system; purchase only  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5165          | Home modifications; per service   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5170          | Home delivered meals, including preparation; per meal                                 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5175          | Laundry service, external, professional; per order                                    | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5181          | Home health respiratory therapy, nos, per diem  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S5185          | Medication reminder service, non-face-to-face; per month  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5199          | Personal care item, nos, each   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| S5199          | Personal care item, nos, each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S5497          | Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| S8035          | Magnetic source imaging   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2009       | 12/31/2999  |
| S8040          | Topographic brain mapping   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 3/1/2024       | 12/31/2999  |
| S8189          | Tracheostomy supply, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S8270          | Enuresis alarm, using auditory buzzer and/or vibration device   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 7/1/2005       | 12/31/2999  |
| S8301          | Infection control supplies, not otherwise specified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| S8415          | Supplies for home delivery of infant  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S8460          | Camisole, post-mastectomy   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S8930          | Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient   | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2019      | 12/31/2999  |
| S8948          | Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 9/24/2012      | 12/31/2999  |
| S9002          | Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device                    | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 4/1/2024       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S9055          | Procuren or other growth factor preparation to promote wound healing  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 11/1/2019      | 12/31/2999  |
| S9125          | Respite care, in the home, per diem   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9379          | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| S9436          | Childbirth preparation/lamaze classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9437          | Childbirth refresher classes, non-physician provider, per session   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9438          | Cesarean birth classes, non-physician provider, per session   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9439          | Vbac (vaginal birth after cesarean) classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9444          | Parenting classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S9445          | Patient education, not otherwise classified, non-physician provider, individual, per session  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| S9446          | Patient education, not otherwise classified, non-physician provider, group, per session   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| S9447          | Infant safety (including cpr) classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9449          | Weight management classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9451          | Exercise classes, non-physician provider, per session   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9454          | Stress management classes, non-physician provider, per session  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9482          | Family stabilization services, per 15 minutes   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2005       | 12/31/2999  |
| S9542          | Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| S9558          | Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/1950       | 12/31/2999  |
| S9810          | Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)      | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| S9900          | Services by a journal-listed christian science practitioner for the purpose of healing, per diem  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9960          | Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| S9961          | Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 1/1/2014       | 12/31/2999  |
| S9970          | Health club membership, annual  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| S9976          | Lodging, per diem, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |

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

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| S9992          | Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S9994          | Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S9996          | Meals for clinical trial participant and one caregiver/companion   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| S9999          | Sales tax  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950       | 12/31/2999  |
| T1005          | Respite care services, up to 15 minutes  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| T1009          | Child sitting services for children of the individual receiving alcohol and/or substance abuse services  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| T1010          | Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| T1012          | Alcohol and/or substance abuse services, skills development  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| T1014          | Telehealth transmission, per minute, professional services bill separately   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |
| T1018          | School-based individualized education program (iep) services, bundled  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| T1040          | Medicaid certified community behavioral health clinic services, per diem  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| T1041          | Medicaid certified community behavioral health clinic services, per month   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| T1505          | Electronic medication compliance management device, includes all components and accessories, not otherwise classified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| T1999          | Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| T2012          | Habilitation, educational; waiver, per diem   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2013          | Habilitation, educational, waiver; per hour   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2014          | Habilitation, prevocational, waiver; per diem   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| T2015          | Habilitation, prevocational, waiver; per hour              | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2016          | Habilitation, residential, waiver; per diem                | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2017          | Habilitation, residential, waiver; 15 minutes              | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2018          | Habilitation, supported employment, waiver; per diem       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2019          | Habilitation, supported employment, waiver; per 15 minutes | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2020          | Day habilitation, waiver; per diem                         | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| T2021          | Day habilitation, waiver; per 15 minutes            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2024          | Service assessment/plan of care development, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2024          | Service assessment/plan of care development, waiver | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 4/1/2026       | 12/31/2999  |
| T2025          | Waiver services; not otherwise specified (nos)      | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2026          | Specialized childcare, waiver; per diem             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2027          | Specialized childcare, waiver; per 15 minutes       | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2028          | Specialized supply, not otherwise specified, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| T2029          | Specialized medical equipment, not otherwise specified, waiver     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| T2030          | Assisted living, waiver; per month                                 | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2031          | Assisted living; waiver, per diem                                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2032          | Residential care, not otherwise specified (nos), waiver; per month | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2033          | Residential care, not otherwise specified (nos), waiver; per diem  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2034          | Crisis intervention, waiver; per diem                              | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| T2035          | Utility services to support medical equipment and assistive technology/devices, waiver | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2036          | Therapeutic camping, overnight, waiver; each session                                   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2037          | Therapeutic camping, day, waiver; each session   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2038          | Community transition, waiver; per service  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2039          | Vehicle modifications, waiver; per service   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T2040          | Financial management, self-directed, waiver; per 15 minutes                            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| T2041          | Supports brokerage, self-directed, waiver; per 15 minutes     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| T5999          | Supply, not otherwise specified                               | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 7/1/2008       | 12/31/2999  |
| V2025          | Deluxe frame  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/2021       | 12/31/2999  |
| V2199          | Not otherwise classified, single vision lens                  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| V2219          | Bifocal seg width over 28mm                                   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V2599          | Contact lens, other type                                      | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| V2600          | Hand held low vision aids and other nonspectacle mounted aids | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V2610          | Single lens spectacle mounted low vision aids                 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |

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

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| V2755          | U-v lens, per lens                                  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V2760          | Scratch resistant coating, per lens                 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V2770          | Occluder lens, per lens                             | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V2787          | Astigmatism correcting function of intraocular lens | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/15/2008     | 12/31/2999  |
| V2788          | Presbyopia correcting function of intraocular lens  | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.                              | 10/15/2008     | 12/31/2999  |
| V2799          | Vision item or service, miscellaneous               | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| V2799          | Vision item or service, miscellaneous               | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| V5090          | Dispensing fee, unspecified hearing aid             | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| V5267          | Hearing aid or assistive listening device/supplies/accessories, not otherwise specified | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| V5274          | Assistive listening device, not otherwise specified                                     | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| V5287          | Assistive listening device, personal fm/dm receiver, not otherwise specified            | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 10/24/2019     | 12/31/2999  |
| V5298          | Hearing aid, not otherwise classified   | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| V5299          | Hearing service, miscellaneous  | Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement. | 1/1/1950       | 12/31/2999  |
| V5364          | Dysphagia screening   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 1/1/1950       | 12/31/2999  |
| 20560          | Needle insertion(s) without injection(s); 1 or 2 muscle(s)                              | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.   | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 20561          | Needle insertion(s) without injection(s); 3 or more muscles  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| 92145          | Corneal hysteresis determination by air impulse stimulation unilateral or bilateral with interpretation and report   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| 92548          | Computerized dynamic posturography sensory organization test (CDP-SOT) 6 conditions (ie eyes open eyes closed visual sway platform sway eyes closed platform sway platform and visual sway) including interpretation and report;   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| 92549          | Computerized dynamic posturography sensory organization test (CDP-SOT) 6 conditions (ie eyes open eyes closed visual sway platform sway eyes closed platform sway platform and visual sway) including interpretation and report; with motor control test (MCT) and adaptation test (ADT) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| G0460          | Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers including as applicable phlebotomy centrifugation or mixing and all other preparatory procedures administration and dressings per treatment  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| P9020          | Platelet rich plasma each unit   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/1/2020      | 12/31/2999  |
| 83695          | Lipoprotein (a)  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| 83698          | Lipoprotein-associated phospholipase A2 (Lp-PLA2)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| 83701          | Lipoprotein blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg electrophoresis ultracentrifugation)                      | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| 83704          | Lipoprotein blood; quantitation of lipoprotein particle number(s) (eg by nuclear magnetic resonance spectroscopy) includes lipoprotein particle subclass(es) when performed                     | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| 83722          | Lipoprotein direct measurement; small dense LDL cholesterol   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| 84112          | Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg placental alpha microglobulin-1 [PAMG-1] placental protein 12 [PP12] alpha-fetoprotein) qualitative each specimen | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0840          | Traction frame attached to headboard cervical traction  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0849          | TRACTION EQUIPMENT CERVICAL FREE-STANDING STAND/FRAME PNEUMATIC APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0850          | Traction stand free standing cervical traction  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0856          | Cervical traction device with inflatable air bladder(s)   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |

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| E0860          | Traction equipment overdoor cervical  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0890          | Traction frame attached to footboard pelvic traction  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0942          | Cervical head harness/halter  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| E0944          | Pelvic belt/harness/boot  | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2020       | 12/31/2999  |
| 0052U          | Lipoprotein blood high resolution fractionation and quantitation of lipoproteins including all five major lipoprotein classes and subclasses of HDL LDL and VLDL by vertical auto profile ultracentrifugation | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2018       | 12/31/2999  |
| 82523          | Collagen cross links any method   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/15/2014     | 12/31/2999  |
| E0830          | Ambulatory traction device all types each   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/15/2014     | 12/31/2999  |
| E0855          | Cervical traction equipment not requiring additional stand or frame   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/15/2014     | 12/31/2999  |
| S9090          | Vertebral axial decompression per session   | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 12/15/2014     | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0408T          | Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0409T          | Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; pulse generator only                        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0410T          | Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; atrial electrode only                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0411T          | Insertion or replacement of permanent cardiac contractility modulation system including contractility evaluation when performed and programming of sensing and therapeutic parameters; ventricular electrode only                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0412T          | Removal of permanent cardiac contractility modulation system; pulse generator only   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0413T          | Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0414T          | Removal and replacement of permanent cardiac contractility modulation system pulse generator only   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0415T          | Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0416T          | Relocation of skin pocket for implanted cardiac contractility modulation pulse generator  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0417T          | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis including review and report implantable cardiac contractility modulation system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0418T          | Interrogation device evaluation (in person) with analysis review and report includes connection recording and disconnection per patient encounter implantable cardiac contractility modulation system   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0571T          | Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s) including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation induction of arrhythmia evaluation of sensing for arrhythmia termination and programming or reprogramming of sensing or therapeutic parameters) when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0572T          | Insertion of substernal implantable defibrillator electrode  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0573T          | Removal of substernal implantable defibrillator electrode  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0574T          | Repositioning of previously implanted substernal implantable defibrillator-pacing electrode  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0575T          | Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis review and report by a physician or other qualified health care professional                                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0576T          | Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode with analysis review and report by a physician or other qualified health care professional includes connection recording and disconnection per patient encounter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0577T          | Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation induction of arrhythmia evaluation of sensing for arrhythmia termination and programming or reprogramming of sensing or therapeutic parameters) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0578T          | Interrogation device evaluation(s) (remote) up to 90 days substernal lead implantable cardioverter-defibrillator system with interim analysis review(s) and report(s) by a physician or other qualified health care professional   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0579T          | Interrogation device evaluation(s) (remote) up to 90 days substernal lead implantable cardioverter-defibrillator system remote data acquisition(s) receipt of transmissions and technician review technical support and distribution of results  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0580T          | Removal of substernal implantable defibrillator pulse generator only   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0587T          | Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator including analysis programming and imaging guidance when performed posterior tibial nerve   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0588T          | Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator including analysis programming and imaging guidance when performed posterior tibial nerve  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0589T          | Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional posterior tibial nerve 1-3 parameters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0590T          | Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg electrode array and receiver) including contact group(s) amplitude pulse width frequency (Hz) on/off cycling burst dose lockout patient-selectable parameters responsive neurostimulation detection algorithms closed-loop parameters and passive parameters when performed by physician or other qualified health care professional posterior tibial nerve 4 or more parameters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0614T          | Removal and replacement of substernal implantable defibrillator pulse generator   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0655T          | Transperineal focal laser ablation of malignant prostate tissue including transrectal imaging guidance with MR-fused images or other enhanced ultrasound imaging  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 0963T          | Anoscopy with directed submucosal injection of bulking agent into anal canal  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 52443          | Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter including transrectal ultrasound and fluoroscopy when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 53865          | Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie pressure necrosis) of bladder neck and prostate   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 53866          | Catheterization with removal of temporary device for ischemic remodeling (ie pressure necrosis) of bladder neck and prostate   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| 55880          | Ablation of malignant prostate tissue transrectal with high intensity-focused ultrasound (HIFU) including ultrasound guidance  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| A4545          | Supplies and accessories for external tibial nerve stimulator (e.g. socks gel pads electrodes etc.) needed for one month   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| C1824          | Generator cardiac contractility modulation (implantable)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E0736          | Transcutaneous tibial nerve stimulator   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| E0737          | Transcutaneous tibial nerve stimulator controlled by phone application   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| K1030          | External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator replacement only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4368          | Amchothick per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4369          | Amnioplast 3 per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4370          | Aeroguard per square centimeter (add-on list separately in addition to primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4371          | Neoguard per square centimeter (add-on list separately in addition to primary procedure)           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4372          | Amchoplast excel per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4373          | Membrane wrap lite per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4375          | Duograft ac per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4376          | Duograft aa per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4377          | Trigraft ft per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

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|----------------|---|--|----------------|-------------|
| Q4378          | Renew ft matrix per square centimeter (add-on list separately in addition to primary procedure)         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4379          | Amniodefend ft matrix per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4380          | Advograft one per square centimeter (add-on list separately in addition to primary procedure)           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4382          | Advograft dual per square centimeter (add-on list separately in addition to primary procedure)          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4383          | Axolotl graft ultra per square centimeter (add-on list separately in addition to primary procedure)     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4384          | Axolotl dualgraft ultra per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4385          | Apollo ft per square centimeter (add-on list separately in addition to primary procedure)      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4386          | Acesso trifaca per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4387          | Neothelium ft per square centimeter (add-on list separately in addition to primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4388          | Neothelium 4l per square centimeter (add-on list separately in addition to primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4389          | Neothelium 4l+ per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4390          | Ascendion per square centimeter (add-on list separately in addition to primary procedure)      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4391          | Amnioplast double per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4393          | Surgraft ac per square centimeter (add-on list separately in addition to primary procedure)       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4394          | Surgraft aca per square centimeter (add-on list separately in addition to primary procedure)      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4395          | Acelagraft per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4396          | Natalin per square centimeter (add-on list separately in addition to primary procedure)           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |
| Q4397          | Summit aaa per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2026      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0616U          | Neurology (dementia) DNA methylation analysis of more than 30 000 sites whole blood algorithm reported as positive or negative risk  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0617U          | Cardiovascular (atherosclerotic cardiovascular disease [ASCVD]) DNA methylation analysis of more than 20 000 sites whole blood algorithm reported as positive or negative risk | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0618U          | Psychiatry (bipolar disorder) DNA methylation analysis of more than 10 000 sites whole blood algorithm reported as positive or negative risk                                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0619U          | Pulmonary (chronic obstructive pulmonary disease [COPD]) DNA methylation analysis of more than 18 000 sites whole blood algorithm reported as positive or negative risk        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0620U          | Oncology (hepatocellular carcinoma) DNA methylation analysis of more than 5 000 sites whole blood algorithm reported as positive or negative risk                              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0621U          | Infectious disease (Lyme borreliosis) DNA methylation analysis of more than 10 000 sites whole blood algorithm reported as positive or negative risk                           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0622U          | Psychiatry (major depressive disorder) DNA methylation analysis of more than 20 000 sites whole blood algorithm reported as positive or negative risk | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0623U          | Autoimmune (multiple sclerosis) DNA methylation analysis of more than 5 000 sites whole blood algorithm reported as positive or negative risk         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0624U          | Hepatology (nonalcoholic steatohepatitis [NASH]) DNA methylation analysis of 5 000 sites whole blood algorithm reported as positive or negative risk  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0625U          | Endocrinology (osteoporosis) DNA methylation analysis of more than 5 000 sites whole blood algorithm reported as positive or negative risk            | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0626U          | Neurology (Parkinson disease) DNA methylation analysis of more than 20 000 sites whole blood algorithm reported as positive or negative risk          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0627U          | Psychiatry (schizophrenia) DNA methylation analysis of more than 15 000 sites whole blood algorithm reported as positive or negative risk             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0629U          | Infectious disease (tuberculosis) DNA analysis of 1 target by PCR with clustered regularly interspaced short palindromic repeat (CRISPR)-based probe detection plasma or serum qualitative report as detected or not detected | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A2040          | Microlyte painguard per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A2041          | Foundation drs+ duo per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A2042          | Foundation drs+ solo per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A2043          | Biobrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A2044          | Biobrane glove each   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2045          | Novashield or novogen wound matrix per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A8005          | Powered cable driven grip assist glove hand finger includes microprocessor pressure sensors all components and accessories custom fitted | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A8006          | Powered cable driven grip assist glove hand finger includes pressure sensors glove replacement only                                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| A9294          | Prescription digital cognitive and/or behavioral therapy biofeedback fda cleared per course of treatment                                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4418          | Biolab membrane wrap flow per square centimeter (add-on list separately in addition to primary procedure)                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4419          | Biolab membrane wrap lite flow per square centimeter (add-on list separately in addition to primary procedure)                           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4421          | Biolab membrane wrap solo per square centimeter (add-on list separately in addition to primary procedure)        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4422          | A/c wrap per square centimeter (add-on list separately in addition to primary procedure)                         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4423          | Biolab tri-membrane wrap flow per square centimeter (add-on list separately in addition to primary procedure)    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4424          | Revive ft per square centimeter (add-on list separately in addition to primary procedure)                        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4425          | Revive tl per square centimeter (add-on list separately in addition to primary procedure)                        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4426          | Dermabind tl + or dermabind tl x per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4427          | Dermabind dl n or dermabind dl + or dermabind dl x per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4428          | Dermabind sl n or dermabind sl + or dermabind sl x per square centimeter (add-on list separately in addition to primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4429          | Dermabind ch n or dermabind ch x per square centimeter (add-on list separately in addition to primary procedure)                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4435          | Renati membrane per square centimeter (add-on list separately in addition to primary procedure)                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4436          | Renati ac membrane per square centimeter (add-on list separately in addition to primary procedure)                                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4437          | Revival ac per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4438          | Prelect per square centimeter (add-on list separately in addition to primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4439          | Instagraft per square centimeter (add-on list separately in addition to primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| Q4440          | Curamatrix per square centimeter (add-on list separately in addition to primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2026       | 12/31/2999  |
| 0937T          | External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording scanning analysis with report review and interpretation by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0938T          | External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0939T          | External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0940T          | External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; Review and interpretation by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0941T          | Cystourethroscopy flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0942T          | Cystourethroscopy flexible; with removal and replacement of prostatic urethral scaffold   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0943T          | Cystourethroscopy flexible; with removal of prostatic urethral scaffold   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0944T          | 3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0945T          | Intraoperative assessment for abnormal (tumor) tissue in-vivo following partial mastectomy (eg lumpectomy) using computer-aided fluorescence imaging  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0946T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0951T          | Totally implantable active middle ear hearing implant; initial placement including mastoidectomy placement of and attachment to sound processor   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0952T          | Totally implantable active middle ear hearing implant; revision or replacement with mastoidectomy and replacement of sound processor  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0953T          | Totally implantable active middle ear hearing implant; revision or replacement without mastoidectomy and replacement of sound processor   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0954T          | Totally implantable active middle ear hearing implant; replacement of sound processor only with attachment to existing transducers  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0955T          | Totally implantable active middle ear hearing implant; removal including removal of sound processor and all implant components  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0956T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0957T          | Revision of sub-scalp implanted electrode array receiver and telemetry unit for electrode when required including imaging guidance  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0958T          | Removal of sub-scalp implanted electrode array receiver and telemetry unit for continuous bilateral electroencephalography monitoring system including imaging guidance   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0959T          | Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system including imaging guidance   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0960T          | Replacement of sub-scalp implanted electrode array receiver and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system including imaging guidance                                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0961T          | 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)                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0962T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0967T          | Transanal insertion of endoluminal temporary colorectal anastomosis protection device including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0968T          | Insertion or replacement of epicranial neurostimulator system including electrode array and pulse generator with connection to electrode array   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0969T          | Removal of epicranial neurostimulator system   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0970T          | Ablation benign breast tumor (eg fibroadenoma) percutaneous laser including imaging guidance when performed each tumor   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0971T          | Ablation malignant breast tumor(s) percutaneous laser including imaging guidance when performed unilateral   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0972T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0973T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0974T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0975T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0976T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0977T          | Upper gastrointestinal blood detection sensor capsule with interpretation and report  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0981T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0982T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0983T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0984T          | 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)         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0985T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0986T          | 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)         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0987T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0990T          | Transcervical instillation of biodegradable hydrogel materials intrauterine  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0991T          | Cystourethroscopy with low-energy lithotripsy and acoustically actuated microspheres including imaging   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0992T          | 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                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 0993T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0994T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0995T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0996T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 0997T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0998T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 0999T          | Autologous muscle cell therapy harvesting of muscle progenitor cells including ultrasound guidance when performed   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1000T          | Autologous muscle cell therapy administration of muscle progenitor cells into the urethral sphincter including cystoscopy and post-void residual ultrasound when performed  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 1001T          | Autologous muscle cell therapy injection of muscle progenitor cells into the external anal sphincter including ultrasound guidance when performed   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1002T          | Air displacement plethysmography whole-body composition assessment with interpretation and report   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1003T          | Arthroplasty first carpometacarpal joint with distal trapezial and proximal first metacarpal prosthetic replacement (eg first carpometacarpal total joint)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1004T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1005T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 1006T          | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1007T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1008T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1009T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 1010T          | 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   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1011T          | Photobiomodulation (PBM) therapy of oral cavity including placement of an oral device monitoring of patient tolerance to treatment and removal of the oral device   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1012T          | Motorized ab interno trephination of sclera (sclerostomy) or trabecular meshwork (trabeculostomy) 1 or more including injection of antifibrotic agents when performed   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1013T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1014T          | Laparoscopic revision or removal lower esophageal sphincter neurostimulator electrodes  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 1015T          | Revision or removal lower esophageal sphincter neurostimulator pulse generator or receiver   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1016T          | 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  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1017T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 1018T          | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1020T          | Raman spectroscopy of 1 or more skin lesions with probability score for malignant risk derived by algorithmic analysis of data from each lesion   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1021T          | Active thoracic irrigation (separate procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1022T          | Percutaneous tissue displacement any method including imaging guidance; intra-abdominal/pelvic structures (List separately in addition to code for primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1023T          | Percutaneous tissue displacement any method including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 1024T          | Percutaneous tissue displacement any method including imaging guidance; soft tissue (List separately in addition to code for primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| 1025T          | Alternating electric fields dosimetry and delivery-simulation modeling creation and selection of patient-specific array layouts and placement verification  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2026       | 12/31/2999  |
| C8003          | Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia open includes measurements positioning and adjustments with imaging guidance (eg fluoroscopy) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2025     | 12/31/2999  |
| A2030          | Miro3d fibers per milligram   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| A2031          | Mirodry wound matrix per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| A2032          | Myriad matrix per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2033          | Myriad morcells 4 milligrams   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| A2034          | Foundation drs solo per square centimeter                                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| A2035          | Corplex p or theracor p or allacor p per milligram                             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4354          | Palingen dual-layer membrane per square centimeter                             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4355          | Abiomend xplus membrane and abiomend xplus hydromembrane per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4356          | Abiomend membrane and abiomend hydromembrane per square centimeter             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |

| Procedure Code | Code Description                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|-------------------------------------|--|----------------|-------------|
| Q4357          | Xwrap plus per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4358          | Xwrap dual per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4359          | Choriplus per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4360          | Amchoplast fd per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4361          | Epixpress per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4362          | Cygnus disk per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4363          | Amnio burgeon membrane and hydromembrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4364          | Amnio burgeon xplus membrane and xplus hydromembrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4365          | Amnio burgeon dual-layer membrane per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4366          | Dual layer amnio burgeon x-membrane per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| Q4367          | Amniocore sl per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/15/2025      | 12/31/2999  |
| C8002          | Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| C9807          | Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| G0552          | Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| G0553          | First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| G0554          | Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4346          | Shelter dm matrix, per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4347          | Rampart dl matrix, per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4348          | Sentry sl matrix, per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4349          | Mantle dl matrix, per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |

| Procedure Code | Code Description                          | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4350          | Palisade dm matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4351          | Enclose tl matrix, per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4352          | Overlay sl matrix, per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| Q4353          | Xceed tl matrix, per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/15/2025      | 12/31/2999  |
| A2027          | Matriderm per square centimeter           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| A2028          | Micromatrix flex per mg                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2029          | Mirotract wound matrix sheet per cubic centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| A4543          | Supplies for transcutaneous electrical nerve stimulator for nerves in the auricular region per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| E0721          | Transcutaneous electrical nerve stimulator for nerves in the auricular region                        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4334          | Amnioplast 1 per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4335          | Amnioplast 2 per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4336          | Artacent c per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |

| Procedure Code | Code Description                        | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4337          | Artacent trident per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4338          | Artacent velos per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4339          | Artacent vericlen per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4340          | Simpligraft per square centimeter       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4341          | Simplimax per square centimeter         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4342          | Theramend per square centimeter         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4343          | Dermacyte ac matrix amniotic membrane allograft per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4344          | Tri-membrane wrap per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| Q4345          | Matrix hd allograft dermis per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2025      | 12/31/2999  |
| 53451          | Periurethral transperineal adjustable balloon continence device; bilateral insertion including cystourethroscopy and imaging guidance  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |
| 53452          | Periurethral transperineal adjustable balloon continence device; unilateral insertion including cystourethroscopy and imaging guidance | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |
| 53453          | Periurethral transperineal adjustable balloon continence device; removal each balloon  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 53454          | Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |
| K1037          | Docking station for use with oral device/appliance used to reduce upper airway collapsibility                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |
| Q4226          | MyOwn skin includes harvesting and preparation procedures per square centimeter                                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024      | 12/31/2999  |
| Q4279          | Vendaje ac per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4287          | Dermabind dl per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4288          | Dermabind ch per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4289          | Revoshield + amniotic barrier per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4290          | Membrane wrap-hydro per square centimeter           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4291          | Lamellas xt per square centimeter                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4292          | Lamellas per square centimeter                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4293          | Acesso dl per square centimeter                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4294          | Amnio quad-core per square centimeter               | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |

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

| Procedure Code | Code Description                      | Code Group & Description   | Effective Date | Ending Date |
|----------------|---------------------------------------|--|----------------|-------------|
| Q4301          | Activate matrix per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4302          | Complete aca per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4303          | Complete aa per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4311          | Acesso per square centimeter          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4312          | Acesso ac per square centimeter       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4313          | Dermabind fm per square centimeter    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4314          | Reeva ft per square centimeter                               | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4315          | Regenelink amniotic membrane allograft per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4316          | Amchoplast per square centimeter                             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4317          | Vitograft per square centimeter                              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4318          | E-graft per square centimeter                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4319          | Sanograft per square centimeter                              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |

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

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

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4332          | Axolotl dualgraft per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| Q4333          | Ardeograft per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024       | 12/31/2999  |
| 53855          | Insertion of a temporary prostatic urethral stent including urethral measurement  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 22836          | Anterior thoracic vertebral body tethering including thoracoscopy when performed; up to 7 vertebral segments                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 22837          | Anterior thoracic vertebral body tethering including thoracoscopy when performed; 8 or more vertebral segments                                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 22838          | Revision (eg augmentation division of tether) replacement or removal of thoracic vertebral body tethering including thoracoscopy when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 27278          | Arthrodesis sacroiliac joint percutaneous with image guidance including placement of intra-articular implant(s) (eg bone allograft[s] synthetic device[s]) without placement of transfixation device                             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 31242          | Nasal/sinus endoscopy surgical; with destruction by radiofrequency ablation posterior nasal nerve  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 31243          | Nasal/sinus endoscopy surgical; with destruction by cryoablation posterior nasal nerve   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33276          | Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]) including vessel catheterization all imaging guidance and pulse generator initial analysis with diagnostic mode activation when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33277          | Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33278          | Removal of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; system including pulse generator and lead(s)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 33279          | Removal of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; transvenous stimulation or sensing lead(s) only             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33280          | Removal of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; pulse generator only  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33281          | Repositioning of phrenic nerve stimulator transvenous lead(s)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33287          | Removal and replacement of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; pulse generator                             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 33288          | Removal and replacement of phrenic nerve stimulator including vessel catheterization all imaging guidance and interrogation and programming when performed; transvenous stimulation or sensing lead(s)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 52284          | Cystourethroscopy with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis male including fluoroscopy when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 93150          | Therapy activation of implanted phrenic nerve stimulator system including all interrogation and programming | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 93151          | Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 93152          | Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| 93153          | Interrogation without programming of implanted phrenic nerve stimulator system                              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| A4542          | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| C1832          | Autograft suspension including cell processing and application and all system components                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| E0732          | Cranial electrotherapy stimulation (ces) system any type                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| E0734          | External upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024      | 12/31/2999  |
| A2026          | Restrata minimatrix 5 mg  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| Q4305          | American amnion ac tri-layer per square centimeter                          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| Q4306          | American amnion ac per square centimeter                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| Q4307          | American amnion per square centimeter                                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4308          | Sanopellis per square centimeter                                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| Q4309          | Via matrix per square centimeter                                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| Q4310          | Procenta per 100 mg  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024       | 12/31/2999  |
| A4560          | Neuromuscular electrical stimulator (nmes) disposable replacement only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024      | 12/31/2999  |
| Q4272          | Esano a per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4273          | Esano aaa per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |

| Procedure Code | Code Description                               | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4274          | Esano ac per square centimeter                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4275          | Esano aca per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4276          | Orion per square centimeter                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4278          | Epieffect per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4280          | Xcell amnio matrix per square centimeter       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4281          | Barrera sl or barrera dl per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4282          | Cygnus dual per square centimeter                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| Q4284          | Dermabind sl per square centimeter                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023      | 12/31/2999  |
| A2022          | Innovaburn or innovamatrix xl per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| A2023          | Innovamatrix pd 1 mg                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| A2024          | Resolve matrix or xenopatch per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| A2025          | Miro3d per cubic centimeter                         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| E0490          | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle controlled by hardware remote  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| E0491          | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle used in conjunction with the power source and control electronics unit controlled by hardware remote 90-day supply | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| K1036          | Supplies and accessories (e.g. transducer) for low frequency ultrasonic diathermy treatment device per month   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| L5991          | Addition to lower extremity prostheses osseointegrated external prosthetic connector   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| Q4285          | Nudyn dl or nudyn dl mesh per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |
| Q4286          | Nudyn sl or nudyn slw per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A2019          | Kerecis omega3 marigen shield per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| A2020          | Ac5 advanced wound system (ac5)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| A2021          | Neomatrix per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| A7049          | Expiratory positive airway pressure intranasal resistance valve   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| C1827          | Generator neurostimulator (implantable) non-rechargeable with implantable stimulation lead and external paired stimulation controller | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4265          | Neostim tl per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |

| Procedure Code | Code Description                       | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4266          | Neostim membrane per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4267          | Neostim dl per square centimeter       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4268          | Surgraft ft per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4269          | Surgraft xt per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4270          | Complete sl per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |
| Q4271          | Complete ft per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2014          | Omeza collagen matrix per 100 mg   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |
| A2015          | Phoenix wound matrix per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |
| A2016          | Permeaderm b per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |
| A2017          | Permeaderm glove each  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |
| A2018          | Permeaderm c per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |
| A4596          | Cranial electrotherapy stimulation (ces) system supplies and accessories per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 22526          | Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; single level  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 22527          | Percutaneous intradiscal electrothermal annuloplasty unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 22867          | Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; single level   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 22868          | Insertion of interlaminar/interspinous process stabilization/distraction device without fusion including image guidance when performed with open decompression lumbar; second level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 22869          | Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; single level   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 22870          | Insertion of interlaminar/interspinous process stabilization/distraction device without open decompression or fusion including image guidance when performed lumbar; second level (List separately in addition to code for primary procedure)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 62287          | Decompression procedure percutaneous of nucleus pulposus of intervertebral disc any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization with discography and/or epidural injection(s) at the treated level(s) when performed single or multiple levels lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 0274T          | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection discectomy facetectomy and/or foraminotomy) any method under indirect image guidance (eg fluoroscopic CT) single or multiple levels unilateral or bilateral; cervical or thoracic                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 30469          | Repair of nasal valve collapse with low energy temperature-controlled (ie radiofrequency) subcutaneous/submucosal remodeling   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 43290          | Esophagogastroduodenoscopy flexible transoral; with deployment of intragastric bariatric balloon   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 43291          | Esophagogastroduodenoscopy flexible transoral; with removal of intragastric bariatric balloon(s)   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| 91113          | Gastrointestinal tract imaging intraluminal (eg capsule endoscopy) colon with interpretation and report                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 95919          | Quantitative pupillometry with physician or other qualified health care professional interpretation and report unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| E1632          | Wearable artificial kidney each  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| M0076          | Prolotherapy   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| Q4259          | Celera dual layer or celera dual membrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| Q4260          | Signature apatch per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4261          | Tag per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| Q4262          | Dual layer impax membrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| Q4263          | Surgraft tl per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| Q4264          | Cocoon membrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023       | 12/31/2999  |
| 62263          | Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline enzyme) or mechanical means (eg catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 2 or more days | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| 62264          | Percutaneous lysis of epidural adhesions using solution injection (eg hypertonic saline enzyme) or mechanical means (eg catheter) including radiologic localization (includes contrast when administered) multiple adhesiolysis sessions; 1 day          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| A2011          | Supra sdrn per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| A2012          | Suprathel per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| A2013          | Innovamatrix fs per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| C9757          | Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and excision of herniated intervertebral disc and repair of annular defect with implantation of bone anchored annular closure device including annular defect measurement alignment and sizing assessment and image guidance; 1 interspace lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| Q4224          | Human health factor 10 amniotic patch (hhf10-p) per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |

| Procedure Code | Code Description                                | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4225          | Amniobind or dermabind tl per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| Q4256          | Mlg-complete per square centimeter              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| Q4257          | Relese per square centimeter                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| Q4258          | Enverse per square centimeter                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022       | 12/31/2999  |
| Q4238          | Derm-maxx per square centimeter                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2022       | 12/31/2999  |
| A2001          | Innovamatrix ac per square centimeter           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |

| Procedure Code | Code Description                                     | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2002          | Mirragen advanced wound matrix per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2004          | Xcellistem 1 mg                                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2005          | Microlyte matrix per square centimeter               | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2006          | Novosorb synpath dermal matrix per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2007          | Restrata per square centimeter                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2008          | Theragenesis per square centimeter                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |

| Procedure Code | Code Description                               | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| A2009          | Symphony per square centimeter                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| A2010          | Apis per square centimeter                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| Q4199          | Cygnus matrix per square centimeter            | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| Q4251          | Vim per square centimeter                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| Q4252          | Vendaje per square centimeter                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |
| Q4253          | Zenith amniotic membrane per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| C1823          | Generator neurostimulator (implantable) non-rechargeable with transvenous sensing and stimulation leads  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022       | 12/31/2999  |
| E0764          | FUNCTIONAL NEUROMUSCULAR STIMULATION TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL USED FOR WALKING BY SPINAL CORD INJURED ENTIRE SYSTEM AFTER COMPLETION OF TRAINING PROGRAM   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022       | 12/31/2999  |
| G0465          | Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers using an FDA-cleared device for this indication (includes as applicable administration dressings phlebotomy centrifugation or mixing and all other preparatory procedures per treatment) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022       | 12/31/2999  |
| C9772          | Revascularization endovascular open or percutaneous tibial/peroneal artery(ies) with intravascular lithotripsy includes angioplasty within the same vessel (s) when performed  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021      | 12/31/2999  |
| C9773          | Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s) includes angioplasty within the same vessel(s) when performed  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| C9774          | Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy includes angioplasty within the same vessel (s) when performed                                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021      | 12/31/2999  |
| C9775          | Revascularization endovascular open or percutaneous tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s) and atherectomy includes angioplasty within the same vessel (s) when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021      | 12/31/2999  |
| C9777          | Esophageal mucosal integrity testing by electrical impedance transoral includes esophagoscopy or esophagogastroduodenoscopy  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021      | 12/31/2999  |
| 30468          | Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| C9363          | Skin substitute Integra Meshed Bilayer Wound Matrix per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4103          | OASIS BURN MATRIX PER SQUARE CENTIMETER  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4104          | INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD) PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4110          | PRIMATRIX PER SQUARE CENTIMETER                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4111          | GAMMAGRAFT PER SQUARE CENTIMETER                                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4112          | CYMETRA INJECTABLE 1CC   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4113          | GRAFTJACKET XPRESS INJECTABLE 1CC                                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4115          | ALLOSKIN PER SQUARE CENTIMETER                                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4117          | HYALOMATRIX PER SQUARE CENTIMETER                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4118          | MATRISTEM MICROMATRIX 1 MG                                       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4123          | ALLOSKIN RT PER SQUARE CENTIMETER                                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4124          | OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4125          | ARTHROFLEX PER SQUARE CENTIMETER                                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4126          | Memoderm dermaspan tranzgraft or integuply per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description                   | Code Group & Description   | Effective Date | Ending Date |
|----------------|------------------------------------|--|----------------|-------------|
| Q4127          | TALYMED PER SQUARE CENTIMETER      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4130          | STRATTICE TM PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4134          | Hmatrix per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4135          | Mediskin per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4136          | Ez-derm per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4141          | Alloskin ac per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4142          | Xcm biologic tissue matrix per square centimeter                                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4143          | Repriza per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4146          | Tensix per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4147          | Architect architect px or architect fx extracellular matrix per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4149          | Excellagen 0.1 cc   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4152          | Dermapure per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description                               | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4158          | Kerecis omega3 per square centimeter           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4161          | Bio-connekt wound matrix per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4164          | Helicoll per square centimeter                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4165          | Keramatrix or kerasorb per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4166          | Cytal per square centimeter                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4167          | Truskin per square centimeter                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description                  | Code Group & Description   | Effective Date | Ending Date |
|----------------|-----------------------------------|--|----------------|-------------|
| Q4179          | Flowerderm per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4182          | Transcyte per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4193          | Coll-e-derm per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4195          | Puraply per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4196          | Puraply am per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4200          | Skin te per square centimeter     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4202          | Keroxx (2.5g/cc) 1cc   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4203          | Derma-gide per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4220          | BellaCell HD or Surederm per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4222          | Progenamatrix per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021      | 12/31/2999  |
| Q4175          | Miroderm per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021       | 12/31/2999  |
| C9768          | Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021       | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4249          | Amniplly for topical use only per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021       | 12/31/2999  |
| Q4250          | Amnioamp-mp per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021       | 12/31/2999  |
| Q4254          | Novafix dl per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021       | 12/31/2999  |
| Q4255          | Reguard for topical use only per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021       | 12/31/2999  |
| 61630          | Balloon angioplasty intracranial (eg atherosclerotic stenosis) percutaneous  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| 0062U          | Autoimmune (systemic lupus erythematosus) IgG and IgM analysis of 80 biomarkers utilizing serum algorithm reported with a risk score | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| C9354          | Acellular pericardial tissue matrix of non-human origin (Veritas) per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| C9356          | Tendon porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet) per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| C9358          | Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| C9360          | Dermal substitute native non-denatured collagen neonatal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| C9364          | Porcine implant Permacol per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| G0428          | Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex)                              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| G9147          | Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous by any means guided by the results of measurements for:respiratory quotient; and/or urine urea nitrogen (UUN); and/or arterial venous or capillary glucose; and/or potassium concentration | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| K1004          | Low frequency ultrasonic diathermy treatment device for home use   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| L8605          | Injectable bulking agent dextranomer/hyaluronic acid copolymer implant anal canal 1 ml includes shipping and necessary supplies  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4138          | Biodfence dryflex per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4139          | Amniomatrix or biodmatrix injectable 1 cc  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4140          | Biodfence per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4145          | Epifix injectable 1 mg  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4148          | Neox cord 1k neox cord rt or clarix cord 1k per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4150          | Allowrap ds or dry per square centimeter                          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4153          | Dermavest and plurivest per square centimeter                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4155          | Neoxflo or clariflo 1 mg  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4156          | Neox 100 or clarix 100 per square centimeter                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                      | Code Group & Description   | Effective Date | Ending Date |
|----------------|---------------------------------------|--|----------------|-------------|
| Q4157          | Revitalon per square centimeter       | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4162          | Woundex flow bioskin flow 0.5 cc      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4163          | Woundex bioskin per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4169          | Artacent wound per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4170          | Cygnus per square centimeter          | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4171          | Interfyl 1 mg                         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                 | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4173          | Palingen or palingen xplus per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4174          | Palingen or promatrix 0.36 mg per 0.25 cc        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4176          | Neopatch or therion per square centimeter        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4177          | Floweramnioflo 0.1 cc                            | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4178          | Floweramniopatch per square centimeter           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4180          | Revita per square centimeter                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4181          | Amnio wound per square centimeter                   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4183          | Surgigraft per square centimeter                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4184          | Cellesta or cellesta duo per square centimeter      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4185          | Cellesta flowable amnion (25 mg per cc); per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4188          | Amnioarmor per square centimeter                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4189          | Artacent ac 1 mg                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4190          | Artacent ac per square centimeter               | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4191          | Restorigin per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4192          | Restorigin 1 cc                                 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4194          | Novachor per square centimeter                  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4197          | Puraply xt per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4198          | Genesis amniotic membrane per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                      | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4201          | Matrion per square centimeter                         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4204          | Xwrap per square centimeter                           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4205          | Membrane graft or membrane wrap per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4206          | Fluid flow or fluid GF 1 cc                           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4208          | Novafix per square centimeter                         | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4209          | Surgraft per square centimeter                        | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4211          | Amnion bio or Axobiomembrane per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4212          | Allogen per cc                                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4213          | Ascent 0.5 mg                                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4214          | Cellesta cord per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4215          | Axolotl ambient or axolotl cryo 0.1 mg             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4216          | Artacent cord per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description   | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4217          | Woundfix BioWound Woundfix Plus BioWound Plus Woundfix Xplus or BioWound Xplus per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4218          | Surgicord per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4219          | Surgigraft-dual per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4221          | Amniowrap2 per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4227          | Amniocore per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4229          | Cogenex amniotic membrane per square centimeter  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                             | Code Group & Description   | Effective Date | Ending Date |
|----------------|--|--|----------------|-------------|
| Q4230          | Cogenex flowable amnion per 0.5 cc           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4232          | Corplex per square centimeter                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4233          | Surfactor or nudyn per 0.5 cc                | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4234          | Xcellerate per square centimeter             | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4235          | Amniorepair or altiply per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4236          | Carepatch per square centimeter              | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description                                    | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4237          | Cryo-cord per square centimeter                     | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4239          | Amnio-maxx or amnio-maxx lite per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4240          | Corecyte for topical use only per 0.5 cc            | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4241          | Polycyte for topical use only per 0.5 cc            | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4242          | Amniocyte plus per 0.5 cc                           | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4245          | Amniotext per cc                                    | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| Q4246          | Coretext or protext per cc  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4247          | Amniotext patch per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| Q4248          | Dermacyte amniotic membrane allograft per square centimeter   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| S2117          | Arthroereisis subtalar  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020      | 12/31/2999  |
| 22586          | Arthrodesis pre-sacral interbody technique including disc space preparation discectomy with posterior instrumentation with image guidance includes bone graft when performed L5-S1 interspace | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |
| 43206          | Esophagoscopy flexible transoral; with optical endomicroscopy   | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |

| Procedure Code | Code Description  | Code Group & Description   | Effective Date | Ending Date |
|----------------|---|--|----------------|-------------|
| 43252          | Esophagogastroduodenoscopy flexible transoral; with optical endomicroscopy  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |
| 46707          | Repair of anorectal fistula with plug (eg porcine small intestine submucosa [SIS])  | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |
| 53860          | Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |
| 88375          | Optical endomicroscopic image(s) interpretation and report real-time or referred each endoscopic session                      | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020       | 12/31/2999  |

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