BlueCross BlueShield of Montana

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

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System codes that, based on our medical policy, are: **- Subject to a medical necessity review,** **- Candidates for a Recommended Clinical Review,** **- Not a benefit for our members,** **- Considered experimental, investigational and unproven (EIU), or** **- Not on our prior authorization list (with some exceptions based on members' benefit plans)** **Except as otherwise noted in the date column, these codes are effective on or before January 1, 2026**	**Utilization Management Process** **This file is a searchable PDF. Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.**

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0024U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative	1/1/2018	12/31/2999
0025U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative	1/1/2018	12/31/2999
0052U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	7/1/2018	12/31/2999
0054T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
0055T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
0062U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	12/1/2020	12/31/2999
0063U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0067U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score	4/1/2021	12/31/2999
0071T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	9/1/2020	12/31/2999
0072T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	9/1/2020	12/31/2999
0075T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	1/1/2026	12/31/2999
0076T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0100T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy	1/1/2026	12/31/2999
0101T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	2/15/2015	12/31/2999
0102T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle	2/15/2015	12/31/2999
0105U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)	10/15/2025	12/31/2999
0106T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0106U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion	12/1/2020	12/31/2999
0107T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	2/15/2015	12/31/2999
0108T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	2/15/2015	12/31/2999
0109T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	2/15/2015	12/31/2999
0110T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	2/15/2015	12/31/2999
0119U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardiology, ceramides by liquid chromatography?tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events	9/1/2020	12/31/2999
0164U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastroenterology (irritable bowel syndrome [IBS]), immunoassay for anti-CdtB and anti-vinculin antibodies, utilizing plasma, algorithm for elevated or not elevated qualitative results	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0165U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and probability of peanut allergy	4/1/2020	12/31/2999
0173U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	4/1/2021	12/31/2999
0175U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	4/1/2021	12/31/2999
0176U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cytolethal distending toxin B (CdtB) and vinculin IgG antibodies by immunoassay (ie, ELISA)	7/1/2020	12/31/2999
0178U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction	7/1/2020	12/31/2999
0198T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	12/1/2020	12/31/2999
0200T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0201T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed	1/1/2026	12/31/2999
0202T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	12/1/2020	12/31/2999
0207T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	2/15/2015	12/31/2999
0208T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold), automated; air only	1/1/2026	12/31/2999
0209T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pure tone audiometry (threshold), automated; air and bone	1/1/2026	12/31/2999
0210T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold, automated;	1/1/2026	12/31/2999
0211T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech audiometry threshold, automated; with speech recognition	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0212T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	1/1/2026	12/31/2999
0213T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	9/1/2020	12/31/2999
0214T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0215T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0216T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0217T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0218T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0219T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	12/1/2020	12/31/2999
0220T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	12/1/2020	12/31/2999
0221T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0222T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	12/1/2020	12/31/2999
0224U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	6/1/2023	12/31/2999
0226U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru	6/1/2023	12/31/2999
0232T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed	12/1/2020	12/31/2999
0234T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	1/1/2026	12/31/2999
0235T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	1/1/2026	12/31/2999
0236T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0237T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	1/1/2026	12/31/2999
0238T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	1/1/2026	12/31/2999
0253T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space	1/1/2013	12/31/2999
0255U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Andrology (infertility), sperm-capacitation assessment of ganglioside GM1 distribution patterns, fluorescence microscopy, fresh or frozen specimen, reported as percentage of capacitated sperm and probability of generating a pregnancy score	10/1/2021	12/31/2999
0263T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0263U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 16 central carbon metabolites (ie, ?-ketoglutarate, alanine, lactate, phenylalanine, pyruvate, succinate, carnitine, citrate, fumarate, hypoxanthine, inosine, malate, S-sulfocysteine, taurine, urate, and xanthine), liquid chromatography tandem mass spectrometry (LC-MS/MS), plasma, algorithmic analysis with result reported as negative or positive (with metabolic subtypes of ASD)	10/1/2021	12/31/2999
0264T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	2/15/2015	12/31/2999
0265T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0274T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	1/1/2023	12/31/2999
0278T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	12/1/2020	12/31/2999
0308T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	1/1/2013	12/31/2999
0312U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0322U	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD	2/1/2024	12/31/2999
0330T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tear film imaging, unilateral or bilateral, with interpretation and report	2/15/2015	12/31/2999
0331T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	9/1/2020	12/31/2999
0332T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	9/1/2020	12/31/2999
0335T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of sinus tarsi implant	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0338T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	10/15/2025	12/31/2999
0339T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	10/15/2025	12/31/2999
0342T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	9/1/2020	12/31/2999
0347T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0348T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	2/15/2015	12/31/2999
15999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, excision pressure ulcer	4/16/2015	12/31/2999
0349T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	2/15/2015	12/31/2999
0350T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	2/15/2015	12/31/2999
0351T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real-time intraoperative	1/1/2026	12/31/2999
0352T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred	1/1/2026	12/31/2999
0353T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast, surgical cavity; real-time intraoperative	1/1/2026	12/31/2999
17999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0354T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred	1/1/2026	12/31/2999
0358T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	12/1/2020	12/31/2999
0378T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	12/1/2020	12/31/2999
0379T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	12/1/2020	12/31/2999
0397T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0405U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (pancreatic), 59 methylation haplotype block markers, next-generation sequencing, plasma, reported as cancer signal detected or not detected	10/1/2023	12/31/2999
0407U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported as risk for progressive decline in kidney function	10/15/2025	12/31/2999
0408T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	9/1/2020	12/31/2999
0409T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	9/1/2020	12/31/2999
0410T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0410U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine enrichment, whole blood or plasma, algorithm reported as cancer detected or not detected	10/1/2023	12/31/2999
0411T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	9/1/2020	12/31/2999
0411U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	10/1/2023	12/31/2999
0412T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; pulse generator only	9/1/2020	12/31/2999
0412U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Beta amyloid, A42/40 ratio, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS) and qualitative ApoE isoformspecific proteotyping, plasma combined with age, algorithm reported as presence or absence of brain amyloid pathology	10/1/2023	12/31/2999
0413T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0413U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (hematolymphoid neoplasm), optical genome mapping for copy number alterations, aneuploidy, and balanced/complex structural rearrangements, DNA from blood or bone marrow, report of clinically significant alterations	10/1/2023	12/31/2999
0414T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	9/1/2020	12/31/2999
0415T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	9/1/2020	12/31/2999
0416T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	9/1/2020	12/31/2999
19499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, breast	1/1/1950	12/31/2999
0417T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0418T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	9/1/2020	12/31/2999
0419U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuropsychiatry (eg, depression, anxiety), genomic sequence analysis panel, variant analysis of 13 genes, saliva or buccal swab, report of each gene phenotype	10/1/2023	12/31/2999
0422T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	1/1/2026	12/31/2999
0436U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (lung), plasma analysis of 388 proteins, using aptamer-based proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy	1/1/2024	12/31/2999
0437T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0439T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0440T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0441T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	1/1/2026	12/31/2999
20999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, musculoskeletal system, general	4/16/2015	12/31/2999
0442T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	1/1/2026	12/31/2999
0443T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999
0444T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	1/1/2026	12/31/2999
0445T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	1/1/2026	12/31/2999
0446U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 10 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic risk score for current disease activity	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0447U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 11 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic prognostic risk score for developing a clinical flare	4/1/2024	12/31/2999
21089	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted maxillofacial prosthetic procedure	1/1/1950	12/31/2999
0449T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	9/15/2019	12/31/2999
0450T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	9/15/2019	12/31/2999
0462U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Melatonin levels test, sleep study, 7 or 9 sample melatonin profile (cortisol optional), enzyme-linked immunosorbent assay (ELISA), saliva, screening/preliminary	7/1/2024	12/31/2999
0464T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Visual evoked potential, testing for glaucoma, with interpretation and report	12/1/2020	12/31/2999
0469T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Retinal polarization scan, ocular screening with on-site automated results, bilateral	7/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0472T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	1/1/2026	12/31/2999
0473T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	1/1/2026	12/31/2999
0474T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	7/1/2017	12/31/2999
0479T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	9/1/2020	12/31/2999
0480T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0481T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	9/1/2020	12/31/2999
0485T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	12/1/2020	12/31/2999
0486T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	12/1/2020	12/31/2999
0490U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular-weight melanoma-associated antigen, CD34 and CD45 protein biomarkers, peripheral blood	10/1/2024	12/31/2999
0491U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor (ER) protein biomarker-expressing cells, peripheral blood	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0492U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein biomarker-expressing cells, peripheral blood	10/1/2024	12/31/2999
21299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted craniofacial and maxillofacial procedure	1/1/1950	12/31/2999
0494T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	1/1/2026	12/31/2999
21499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, head	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0495T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	1/1/2026	12/31/2999
0495U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0496T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0501U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)	10/1/2024	12/31/2999
21899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, neck or thorax	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0505T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	1/1/2026	12/31/2999
0506T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	1/1/2026	12/31/2999
0507T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	7/1/2018	12/31/2999
0509T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electroretinography (ERG) with interpretation and report, pattern (PERG)	5/15/2021	12/31/2999
0510T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of sinus tarsi implant	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0510U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype	10/1/2024	12/31/2999
0511T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and reinsertion of sinus tarsi implant	12/1/2020	12/31/2999
0511U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	10/1/2024	12/31/2999
0512T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	1/1/2019	12/31/2999
0513T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	1/1/2019	12/31/2999
0514U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of adalimumab (ADL) levels in venous serum in patients undergoing adalimumab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL)	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0515T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	9/1/2020	12/31/2999
0515U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of infliximab (IFX) levels in venous serum in patients undergoing infliximab therapy, results reported as a numerical value as micrograms per milliliter (ug/mL)	10/1/2024	12/31/2999
0516T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	9/1/2020	12/31/2999
0517T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	9/1/2020	12/31/2999
0518T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0519T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	9/1/2020	12/31/2999
0520T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	9/1/2020	12/31/2999
0521T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	9/1/2020	12/31/2999
0522T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	9/1/2020	12/31/2999
0524T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0525T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	9/1/2020	12/31/2999
0525U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology, spheroid cell culture, 11-drug panel (carboplatin, docetaxel, doxorubicin, etoposide, gemcitabine, niraparib, olaparib, paclitaxel, rucaparib, topotecan, veliparib) ovarian, fallopian, or peritoneal response prediction for each drug	1/1/2025	12/31/2999
0526T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	9/1/2020	12/31/2999
0527T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	9/1/2020	12/31/2999
0528T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0529T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	9/1/2020	12/31/2999
0530T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	9/1/2020	12/31/2999
0531T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	9/1/2020	12/31/2999
0532T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	9/1/2020	12/31/2999
22899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, spine	4/16/2015	12/31/2999
0541T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0541U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardiovascular disease (HDL reverse cholesterol transport), cholesterol efflux capacity, LC-MS/MS, quantitative measurement of 5 distinct HDL-bound apolipoproteins (apolipoproteins A1, C1, C2, C3, and C4), serum, algorithm reported as prediction of coronary artery disease (pCAD) score	4/1/2025	12/31/2999
22999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, musculoskeletal system	4/16/2015	12/31/2999
0542T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report	1/1/2026	12/31/2999
0543T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	1/1/2026	12/31/2999
23929	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, shoulder	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
24999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, humerus or elbow	4/16/2015	12/31/2999
0545T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	1/1/2026	12/31/2999
25999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, forearm or wrist	4/16/2015	12/31/2999
0546T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	1/1/2026	12/31/2999
26989	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hands or fingers	4/16/2015	12/31/2999
0547T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	1/1/2026	12/31/2999
0547U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurofilament light chain (NfL), chemiluminescent enzyme immunoassay, plasma, quantitative	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0554T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone-mineral density, interpretation and report	1/1/2026	12/31/2999
27299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pelvis or hip joint	4/16/2015	12/31/2999
0555T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data	1/1/2026	12/31/2999
27599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, femur or knee	4/16/2015	12/31/2999
0556T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0556U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific DNA and RNA by real-time PCR, 12 targets, nasopharyngeal or oropharyngeal swab, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	7/1/2025	12/31/2999
0557T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; interpretation and report	1/1/2026	12/31/2999
0558T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	1/1/2026	12/31/2999
27899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, leg or ankle	4/16/2015	12/31/2999
0561T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	11/15/2025	12/31/2999
0562T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	11/15/2025	12/31/2999
28899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, foot or toes	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0563T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	12/1/2020	12/31/2999
0563U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 11 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative	7/1/2025	12/31/2999
0564U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 10 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative	7/1/2025	12/31/2999
29799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, casting or strapping	1/1/1950	12/31/2999
0565T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	8/15/2021	12/31/2999
0566T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0568U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurology (dementia), beta amyloid (AB40, AB42, AB42/40 ratio), tau-protein phosphorylated at residue (eg, pTau217), neurofilament light chain (NfL), and glial fibrillary acidic protein (GFAP), by ultra-high sensitivity molecule array detection, plasma, algorithm reported as positive, intermediate, or negative for Alzheimer pathology	7/1/2025	12/31/2999
29999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, arthroscopy	1/1/1950	12/31/2999
0569T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	8/15/2023	12/31/2999
0570T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	8/15/2023	12/31/2999
0571T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
30999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nose	1/1/1950	12/31/2999
0572T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of substernal implantable defibrillator electrode	2/15/2025	12/31/2999
0572U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (prostate), high-throughput telomere length quantification by FISH, whole blood, diagnostic algorithm reported as risk of prostate cancer	7/1/2025	12/31/2999
0573T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of substernal implantable defibrillator electrode	2/15/2025	12/31/2999
0574T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	2/15/2025	12/31/2999
31299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, accessory sinuses	1/1/1950	12/31/2999
0575T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
31599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, larynx	1/1/1950	12/31/2999
0576T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	2/15/2025	12/31/2999
0577T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	2/15/2025	12/31/2999
0578T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	2/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0579T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	2/15/2025	12/31/2999
0580T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of substernal implantable defibrillator pulse generator only	2/15/2025	12/31/2999
0582T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	1/1/2026	12/31/2999
0584T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous	1/1/2020	12/31/2999
31899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, trachea, bronchi	1/1/1950	12/31/2999
0585T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0586T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open	1/1/2020	12/31/2999
0587T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	1/1/2020	12/31/2999
32999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lungs and pleura	1/1/1950	12/31/2999
0588T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0589T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	1/1/2020	12/31/2999
0590T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	1/1/2020	12/31/2999
0591T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health and well-being coaching face-to-face; individual, initial assessment	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0592T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	1/1/2020	12/31/2999
0593T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	1/1/2020	12/31/2999
0594T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	1/1/2026	12/31/2999
0596T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	7/1/2020	12/31/2999
0597T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	7/1/2020	12/31/2999
0598T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time fluorescence wound imaging with, clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; first anatomic site (eg, lower extremity, right leg)	10/1/2024	12/31/2999
0598U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastroenterology (irritable bowel syndrome), IgG antibodies to 18 food items by microarray-based immunoassay, whole blood or serum, report as elevated (positive) or normal (negative) antibody levels	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0599T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time fluorescence wound imaging with, clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; each additional anatomic site (eg, upper extremity, left leg) (List separately in addition to code for primary procedure)	10/1/2024	12/31/2999
0600T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous	7/1/2020	12/31/2999
0601T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open	7/1/2020	12/31/2999
0601U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infectious disease (periprosthetic joint infection), analysis of 11 biomarkers (alpha defensins 1-3, Creactive protein, microbial antigens for Staphylococcus [SPA, SPB], Enterococcus, Candida, and C. acnes, total nucleated cell count, percent neutrophils, RBC count, and absorbance at 280 nm) using immunoassays, hematology, clinical chemistry, synovial fluid, and diagnostic algorithm reported as a probability score	1/1/2026	12/31/2999
0602T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	4/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0602U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endocrinology (diabetes), insulin (INS) gene methylation using digital droplet PCR, insulin, and C peptide immunoassay, serum, Hemoglobin A1c immunoassay, whole blood, algorithm reported as diabetes-risk score	1/1/2026	12/31/2999
0603T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	4/1/2021	12/31/2999
0603U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Drug assay, presumptive, 77 drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS), results reported as positive or negative	1/1/2026	12/31/2999
0604T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	1/1/2026	12/31/2999
0605T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0606T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	1/1/2026	12/31/2999
0607T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	1/1/2026	12/31/2999
0607U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0608T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	1/1/2026	12/31/2999
0608U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations	1/1/2026	12/31/2999
0609T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	1/1/2026	12/31/2999
0610T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0611T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	1/1/2026	12/31/2999
0611U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	1/1/2026	3/31/2026
0612T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	1/1/2026	12/31/2999
0612U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result	1/1/2026	3/31/2026
0613T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0613U	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (urothelial carcinoma), DNA methylation and mutation analysis of 6 biomarkers (TWIST1, OTX1, ONECUT2, FGFR3, HRAS, TERT promoter region), methylation-specific PCR and targeted next-generation sequencing, urine, algorithm reported as a probability index for bladder cancer and upper tract urothelial carcinoma	1/1/2026	3/31/2026
0614T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of substernal implantable defibrillator pulse generator	7/1/2020	12/31/2999
0615T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	5/15/2021	12/31/2999
0620T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0621T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser;	1/1/2021	12/31/2999
33999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, cardiac surgery	1/1/1950	12/31/2999
0622T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	1/1/2021	12/31/2999
36299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular injection	1/1/1950	12/31/2999
0627T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	1/1/2021	12/31/2999
0628T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0629T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	1/1/2021	12/31/2999
0630T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	1/1/2021	12/31/2999
0632T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	1/1/2026	12/31/2999
0639T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	1/1/2021	12/31/2999
0640T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	7/1/2021	12/31/2999
0643T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0644T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed	1/1/2026	12/31/2999
0645T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	1/1/2026	12/31/2999
0646T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	7/1/2021	12/31/2999
0647T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0650T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional	7/1/2021	12/31/2999
0651T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	1/1/2023	12/31/2999
0652T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	1/1/2026	12/31/2999
0653T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	1/1/2026	12/31/2999
0654T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter	1/1/2026	12/31/2999
0655T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging	7/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0656T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	7/1/2021	12/31/2999
0657T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	7/1/2021	12/31/2999
0658T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	1/1/2026	12/31/2999
0659T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation	1/1/2026	12/31/2999
0660T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	1/1/2026	12/31/2999
0661T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	1/1/2026	12/31/2999
0664T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open, from cadaver donor	8/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0665T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); open, from living donor	8/15/2021	12/31/2999
0666T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	8/15/2021	12/31/2999
0667T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	8/15/2021	12/31/2999
0668T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	8/15/2021	12/31/2999
0669T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	8/15/2021	12/31/2999
0670T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	8/15/2021	12/31/2999
0671T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0672T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	1/1/2023	12/31/2999
0673T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	1/1/2026	12/31/2999
0674T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)	1/1/2026	12/31/2999
0675T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead	1/1/2026	12/31/2999
0676T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0677T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead	1/1/2026	12/31/2999
0678T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0679T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0680T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)	1/1/2026	12/31/2999
0681T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0682T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0683T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0684T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999
0685T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0686T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	1/1/2026	12/31/2999
0687T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	1/1/2026	12/31/2999
0688T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	1/1/2026	12/31/2999
0689T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure)	1/1/2026	12/31/2999
0690T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0691T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report	1/1/2026	12/31/2999
0692T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic ultrafiltration	1/1/2022	12/31/2999
0693T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	1/1/2026	12/31/2999
0694T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	1/1/2026	12/31/2999
0695T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0696T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up interrogation or programming device evaluation	1/1/2026	12/31/2999
0697T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	1/1/2026	12/31/2999
0698T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0699T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection, posterior chamber of eye, medication	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0700T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; first lesion	1/1/2026	12/31/2999
0701T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0704T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0705T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	1/1/2026	12/31/2999
0706T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	1/1/2026	12/31/2999
0707T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	1/1/2022	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0719T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	1/1/2026	12/31/2999
0721T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999
37501	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vascular endoscopy procedure	1/1/1950	12/31/2999
0722T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0723T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session	1/1/2026	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0730T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance	1/1/2026	12/31/2999
0731T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative AI-based facial phenotype analysis with report	1/1/2026	12/31/2999
0732T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Immunotherapy administration with electroporation, intramuscular	1/1/2026	12/31/2999
37799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vascular surgery	1/1/1950	12/31/2999
0733T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	1/1/2026	12/31/2999
38129	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spleen	1/1/1950	12/31/2999
0734T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0735T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0736T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	1/1/2026	12/31/2999
0737T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xenograft implantation into the articular surface	1/1/2026	12/31/2999
0738T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	1/1/2026	12/31/2999
0739T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	1/1/2026	12/31/2999
0740T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0741T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	9/1/2023	12/31/2999
0742T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0743T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	1/1/2023	12/31/2999
0744T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0745T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	1/1/2026	12/31/2999
0746T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	1/1/2026	12/31/2999
0747T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	1/1/2026	12/31/2999
0748T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	9/1/2023	12/31/2999
38589	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, lymphatic system	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0749T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;	1/1/2026	12/31/2999
38999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, hemic or lymphatic system	1/1/1950	12/31/2999
0750T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	1/1/2026	12/31/2999
39499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, mediastinum	1/1/1950	12/31/2999
0751T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
39599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, diaphragm	1/1/1950	12/31/2999
0752T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
40799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lips	1/1/1950	12/31/2999
0753T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
40899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, vestibule of mouth	1/1/1950	12/31/2999
0754T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0755T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0756T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0757T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
41599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, tongue, floor of mouth	1/1/1950	12/31/2999
0758T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0759T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
41899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, dentoalveolar structures	1/1/1950	12/31/2999
0760T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0761T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0762T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
42299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, palate, uvula	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0763T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
42699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, salivary glands or ducts	1/1/1950	12/31/2999
0764T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0765T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	1/1/2026	12/31/2999
42999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pharynx, adenoids, or tonsils	1/1/1950	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0773T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	9/1/2023	12/31/2999
0774T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	9/1/2023	12/31/2999
43289	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, esophagus	1/1/1950	12/31/2999
0776T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0777T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	9/1/2023	12/31/2999
0778T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	9/1/2023	12/31/2999
0779T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report	9/1/2023	12/31/2999
0780T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract	1/1/2023	12/31/2999
0781T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	9/1/2023	12/31/2999
0782T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	9/1/2023	12/31/2999
0783T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0784T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed	1/1/2024	12/31/2999
0785T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	1/1/2024	12/31/2999
43499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, esophagus	1/1/1950	12/31/2999
0786T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	1/1/2024	12/31/2999
0787T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	1/1/2024	12/31/2999
0788T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0789T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters	1/1/2024	12/31/2999
0790T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	5/15/2024	12/31/2999
0791T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	7/1/2023	12/31/2999
0792T	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional	7/1/2023	12/31/2999
43659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, stomach	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0793T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	1/1/2026	12/31/2999
0794T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately	7/1/2023	12/31/2999
0794T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately	1/1/2026	12/31/2999
0805T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	7/1/2023	12/31/2999
0805T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0806T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	7/1/2023	12/31/2999
0806T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	1/1/2026	12/31/2999
0807T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	7/1/2023	12/31/2999
0808T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	7/1/2023	12/31/2999
0810T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, stomach	1/1/1950	12/31/2999
44238	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, intestine (except rectum)	1/1/1950	12/31/2999
0811T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	1/1/2026	12/31/2999
44799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, small intestine	1/1/1950	12/31/2999
44899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, Meckel's diverticulum and the mesentery	1/1/1950	12/31/2999
0812T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days	1/1/2026	12/31/2999
44979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, appendix	1/1/1950	12/31/2999
0813T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
45399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, colon	1/1/2015	12/31/2999
0814T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	1/1/2026	12/31/2999
45499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, rectum	1/1/2006	12/31/2999
0815T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine	1/1/2026	12/31/2999
45999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, rectum	1/1/1950	12/31/2999
0816T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0817T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial	1/1/2024	12/31/2999
0818T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	7/1/2024	12/31/2999
46999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anus	1/1/1950	12/31/2999
0819T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial	1/1/2026	12/31/2999
0820T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopic procedure, liver	1/1/1950	12/31/2999
0821T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; second physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0822T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; clinical staff under the direction of a physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
47399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, liver	1/1/1950	12/31/2999
47579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, biliary tract	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, biliary tract	1/1/1950	12/31/2999
0827T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
48999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, pancreas	1/1/1950	12/31/2999
0828T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49329	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
0829T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0830T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
49999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, abdomen, peritoneum and omentum	1/1/1950	12/31/2999
0831T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0832T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0833T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening and interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0834T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0835T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
50549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, renal	1/1/1950	12/31/2999
0837T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0838T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0839T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
50949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, ureter	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0840T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0841T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
51999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, bladder	1/1/2006	12/31/2999
0842T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0843T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), initial site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0844T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), each additional site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0845T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0846T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0847T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0848T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0849T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0850T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0851T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0852T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
53899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, urinary system	1/1/1950	12/31/2999
0853T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0854T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0855T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for bone marrow, smear interpretation (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0856T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Digitization of glass microscope slides for electron microscopy, diagnostic (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0857T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0858T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	10/1/2024	12/31/2999
0859T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0860T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities	1/1/2026	12/31/2999
0861T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	1/1/2024	12/31/2999
0862T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	1/1/2024	12/31/2999
0863T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	1/1/2024	12/31/2999
0864T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0865T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	1/1/2026	12/31/2999
54699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, testis	1/1/1950	12/31/2999
0866T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
55559	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, spermatic cord	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0867T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL	1/1/2026	12/31/2999
0868T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	High-resolution gastric electrophysiology mapping with simultaneous patientsymptom profiling, with interpretation and report	6/15/2025	12/31/2999
0869T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed	1/1/2026	12/31/2999
0870T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	5/15/2025	12/31/2999
0871T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	5/15/2025	12/31/2999
55899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, male genital system	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0872T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	5/15/2025	12/31/2999
0873T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	5/15/2025	12/31/2999
0874T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	5/15/2025	12/31/2999
0875T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	5/15/2025	12/31/2999
0876T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula)	1/1/2026	12/31/2999
0877T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0878T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure	1/1/2026	12/31/2999
0879T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission	1/1/2026	12/31/2999
0880T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
0881T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cryotherapy of the oral cavity using temperature regulated fluid cooling system, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	1/1/2026	12/31/2999
0882T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0883T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0884T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
58578	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, uterus	1/1/1950	12/31/2999
0885T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
58579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hysteroscopy procedure, uterus	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0886T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	1/1/2026	12/31/2999
0887T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
58679	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, oviduct, ovary	1/1/1950	12/31/2999
0888T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance	1/1/2026	12/31/2999
0893T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report	1/1/2026	12/31/2999
0894T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0895T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment)	1/1/2026	12/31/2999
0896T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment) (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
58999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, female genital system (nonobstetrical)	1/1/1950	12/31/2999
0897T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0898T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report	1/1/2026	12/31/2999
0899T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0900T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
59897	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0901T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Placement of bone marrow sampling port, including imaging guidance when performed	1/1/2026	12/31/2999
59898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, maternity care and delivery	1/1/1950	12/31/2999
0902T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	1/1/2026	12/31/2999
59899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, maternity care and delivery	1/1/1950	12/31/2999
0903T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	1/1/2026	12/31/2999
60659	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted laparoscopy procedure, endocrine system	1/1/1950	12/31/2999
0904T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	1/1/2026	12/31/2999
0905T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
60699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, endocrine system	1/1/1950	12/31/2999
0906T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm	1/1/2026	12/31/2999
0907T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0908T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	1/1/2026	12/31/2999
0909T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	1/1/2026	12/31/2999
0910T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of integrated neurostimulation system, vagus nerve	1/1/2026	12/31/2999
0911T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0912T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by physician or other qualified health care professional	1/1/2026	12/31/2999
0913T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	1/1/2026	12/31/2999
0914T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch (List separately in addition to code for percutaneous coronary stent or atherectomy intervention)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0915T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator and dual transvenous electrodes/leads (pacing and defibrillation)	1/1/2025	12/31/2999
0916T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator only	1/1/2025	12/31/2999
0917T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; single transvenous lead (pacing or defibrillation) only	1/1/2025	12/31/2999
0918T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; dual transvenous leads (pacing and defibrillation) only	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0919T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); pulse generator only	1/1/2025	12/31/2999
0920T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous pacing lead only	1/1/2025	12/31/2999
0921T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead only	1/1/2025	12/31/2999
0922T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only	1/1/2025	12/31/2999
0923T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of permanent cardiac contractility modulation defibrillation pulse generator only	1/1/2025	12/31/2999
0924T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters	1/1/2025	12/31/2999
0925T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0926T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation-defibrillation system	1/1/2025	12/31/2999
0927T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system	1/1/2025	12/31/2999
0928T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system with interim analysis and report(s) by a physician or other qualified health care professional	1/1/2025	12/31/2999
0929T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0930T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator	1/1/2025	12/31/2999
0931T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), separate from initial implantation or replacement with testing of cardiac contractility modulation defibrillator pulse generator	1/1/2025	12/31/2999
0932T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
0933T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring, including sensor calibration and deployment, right heart catheterization, transseptal puncture, imaging guidance, and radiological supervision and interpretation	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0934T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of a wireless left atrial pressure sensor for up to 30 days, including data from daily uploads of left atrial pressure recordings, interpretation(s) and trend analysis, with adjustments to the diuretics plan, treatment paradigm thresholds, medications or lifestyle modifications, when performed, and report(s) by a physician or other qualified health care professional	1/1/2026	12/31/2999
0935T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral	1/1/2025	12/31/2999
0936T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation therapy of retina, single session	1/1/2026	12/31/2999
0937T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0938T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)	1/1/2026	12/31/2999
0939T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report	1/1/2026	12/31/2999
0940T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; Review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0941T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization	1/1/2026	12/31/2999
0942T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with removal and replacement of prostatic urethral scaffold	1/1/2026	12/31/2999
0943T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, flexible; with removal of prostatic urethral scaffold	1/1/2026	12/31/2999
0944T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0945T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intraoperative assessment for abnormal (tumor) tissue, in-vivo, following partial mastectomy (eg, lumpectomy) using computer-aided fluorescence imaging	1/1/2026	12/31/2999
0946T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure, including data acquisition, data preparation and transmission, interpretation and report (including CT scan of the joint or extremity performed with paired views)	1/1/2026	12/31/2999
0947T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed	1/1/2025	12/31/2999
0948T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review, and report(s) by a physician or other qualified health care professional	7/1/2025	12/31/2999
0949T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0950T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of benign prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	7/1/2025	12/31/2999
0951T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; initial placement, including mastoidectomy, placement of and attachment to sound processor	1/1/2026	12/31/2999
0952T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement, with mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0953T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; revision or replacement, without mastoidectomy and replacement of sound processor	1/1/2026	12/31/2999
0954T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; replacement of sound processor only, with attachment to existing transducers	1/1/2026	12/31/2999
0955T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Totally implantable active middle ear hearing implant; removal, including removal of sound processor and all implant components	1/1/2026	12/31/2999
0956T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Partial craniectomy, channel creation, and tunneling of electrode for sub-scalp implantation of an electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0957T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision of sub-scalp implanted electrode array, receiver, and telemetry unit for electrode, when required, including imaging guidance	1/1/2026	12/31/2999
64999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, nervous system	1/1/1950	12/31/2999
0958T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of sub-scalp implanted electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0959T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0960T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Replacement of sub-scalp implanted electrode array, receiver, and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system, including imaging guidance	1/1/2026	12/31/2999
0961T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Shortwave infrared radiation imaging, surgical pathology specimen, to assist gross examination for lymph node localization in fibroadipose tissue, per specimen (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0962T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic analysis of acoustic and electrocardiogram recording for detection of cardiac dysfunction (eg, reduced ejection fraction, cardiac murmurs, atrial fibrillation), with review and interpretation by a physician or other qualified health care professional	1/1/2026	12/31/2999
0963T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anoscopy with directed submucosal injection of bulking agent into anal canal	7/1/2025	12/31/2999
0964T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism	7/1/2025	12/31/2999
0965T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism	7/1/2025	12/31/2999
0966T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism	7/1/2025	12/31/2999
0967T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0968T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion or replacement of epicranial neurostimulator system, including electrode array and pulse generator, with connection to electrode array	1/1/2026	12/31/2999
0969T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of epicranial neurostimulator system	1/1/2026	12/31/2999
0970T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor	1/1/2026	12/31/2999
0971T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ablation, malignant breast tumor(s), percutaneous, laser, including imaging guidance when performed, unilateral	1/1/2026	12/31/2999
0972T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Assistive algorithmic classification of burn healing (ie, healing or nonhealing) by noninvasive multispectral imaging, including system set-up and acquisition, selection, and transmission of images, with automated generation of report	1/1/2026	12/31/2999
0973T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; first 100 sq cm	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0974T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
66999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, anterior segment of eye	1/1/1950	12/31/2999
0975T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; first 100 sq cm	1/1/2026	12/31/2999
67299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, posterior segment	1/1/1950	12/31/2999
0976T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; each additional 100 sq cm (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, extraocular muscle	1/1/1950	12/31/2999
0977T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Upper gastrointestinal blood detection, sensor capsule, with interpretation and report	1/1/2026	12/31/2999
0978T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil	7/1/2025	12/31/2999
0979T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; soft palate only	7/1/2025	12/31/2999
0980T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal cryolysis therapy; base of tongue and lingual tonsil only	7/1/2025	12/31/2999
0981T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed	1/1/2026	12/31/2999
67599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, orbit	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0982T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment	1/1/2026	12/31/2999
0983T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	1/1/2026	12/31/2999
0984T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0985T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0986T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0987T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0988T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous and subfascial	1/1/2026	12/31/2999
0989T	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous and subfascial	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0990T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcervical instillation of biodegradable hydrogel materials, intrauterine	1/1/2026	12/31/2999
67999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, eyelids	1/1/1950	12/31/2999
0991T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, with low-energy lithotripsy and acoustically actuated microspheres, including imaging	1/1/2026	12/31/2999
68399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, conjunctiva	1/1/1950	12/31/2999
0992T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
68899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, lacrimal system	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0993T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat with concurrent computed tomography scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
0994T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; percutaneous	1/1/2026	12/31/2999
0995T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; open	1/1/2026	12/31/2999
69399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, external ear	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
0996T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed	1/1/2026	12/31/2999
0997T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location, dose, and intensity for magnetic stimulation therapy, derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram, including automated data processing, transmission, analysis, generation of treatment parameters with review, interpretation, and report	1/1/2026	12/31/2999
0998T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus, utilizing magnetic resonance imaging-based neuronavigation, with management, per day	1/1/2026	12/31/2999
0999T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, middle ear	1/1/1950	12/31/2999
1000T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, administration of muscle progenitor cells into the urethral sphincter, including cystoscopy and post-void residual ultrasound, when performed	1/1/2026	12/31/2999
69949	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, inner ear	1/1/1950	12/31/2999
1001T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed	1/1/2026	12/31/2999
69979	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, temporal bone, middle fossa approach	1/1/1950	12/31/2999
1002T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Air displacement plethysmography, whole-body composition assessment, with interpretation and report	1/1/2026	12/31/2999
1003T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (eg, first carpometacarpal total joint)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1004T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; without programming	1/1/2026	12/31/2999
76496	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
1005T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, first 15 minutes face-to-face time with physician or other qualified health care professional	1/1/2026	12/31/2999
76497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted computed tomography procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1006T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (eg, contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
76498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
1007T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electroencephalogram from implanted sub-scalp continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording, without video	1/1/2026	12/31/2999
76499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic radiographic procedure	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1008T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of sub-scalp implanted continuous bilateral electroencephalography monitoring system, device fitting, initial set-up, and patient education in wearing of system and use of equipment	1/1/2026	12/31/2999
1009T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Remote monitoring of a sub-scalp implanted continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording without video	1/1/2026	12/31/2999
76999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ultrasound procedure (eg, diagnostic, interventional)	1/1/1950	12/31/2999
1010T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computerized ophthalmic analysis of monocular eye movements using retinal-based eye-tracking without spatial calibration, including fixation, microsaccades, drift, and horizontal saccades, when performed, unilateral or bilateral, with interpretation and report	1/1/2026	12/31/2999
77299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology clinical treatment planning	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1011T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Photobiomodulation (PBM) therapy of oral cavity, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	1/1/2026	12/31/2999
77399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	4/16/2015	12/31/2999
1012T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Motorized ab interno trephination of sclera (sclerostomy), or trabecular meshwork (trabeculostomy), 1 or more, including injection of antifibrotic agents, when performed	1/1/2026	12/31/2999
77499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, therapeutic radiology treatment management	1/1/1950	12/31/2999
1013T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopy, surgical, implantation or replacement of lower esophageal sphincter neurostimulator electrode array and neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver, including cruroplasty and/or electronic analysis, when performed	1/1/2026	12/31/2999
77799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure, clinical brachytherapy	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1014T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laparoscopic revision or removal, lower esophageal sphincter neurostimulator electrodes	1/1/2026	12/31/2999
78099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted endocrine procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1015T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision or removal, lower esophageal sphincter neurostimulator pulse generator or receiver	1/1/2026	12/31/2999
78199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1016T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; intraoperative, with programming	1/1/2026	12/31/2999
78299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1017T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, without reprogramming	1/1/2026	12/31/2999
78399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1018T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, with reprogramming	1/1/2026	12/31/2999
1019T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lymphovenous bypass, including robotic assistance, when performed, per extremity	1/1/2026	12/31/2999
78499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
1020T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Raman spectroscopy of 1 or more skin lesions, with probability score for malignant risk derived by algorithmic analysis of data from each lesion	1/1/2026	12/31/2999
78599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted respiratory procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1021T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Active thoracic irrigation (separate procedure)	1/1/2026	12/31/2999
78699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted nervous system procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1022T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; intra-abdominal/pelvic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
78799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted genitourinary procedure, diagnostic nuclear medicine	1/1/1950	12/31/2999
1023T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous procedure, diagnostic nuclear medicine	4/16/2015	12/31/2999
1024T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous tissue displacement, any method, including imaging guidance; soft tissue (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
79999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiopharmaceutical therapy, unlisted procedure	1/1/1950	12/31/2999
1025T	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification	1/1/2026	12/31/2999
3051F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	1/1/2020	12/31/2999
3052F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	1/1/2020	12/31/2999
9001F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm less than 5.0 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT (NMA-No Measure Associated)	1/1/2014	12/31/2999
9002F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm 5.0 - 5.4 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT (NMA-No Measure Associated)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
9003F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT (NMA-No Measure Associated)	1/1/2014	12/31/2999
9004F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT (NMA-No Measure Associated)	1/1/2014	12/31/2999
9005F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Asymptomatic carotid stenosis: No history of any transient ischemic attack or stroke in any carotid or vertebrobasilar territory (NMA-No Measure Associated)	1/1/2014	12/31/2999
9006F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure (NMA-No Measure Associated)	1/1/2014	12/31/2999
9007F	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke (NMA-No Measure Associated)	1/1/2014	12/31/2999
80299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Quantitation of therapeutic drug, not elsewhere specified	1/1/1950	12/31/2999
640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted urinalysis procedure	1/1/1950	12/31/2999
797	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity	1/1/2013	12/31/2999
11920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	1/1/2013	12/31/2999
11921	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	1/1/2013	12/31/2999
11922	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
81479	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted molecular pathology procedure	1/1/2013	12/31/2999
11950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted multianalyte assay with algorithmic analysis	1/1/2013	12/31/2999
11951	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	1/1/2013	12/31/2999
11952	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	1/1/2013	12/31/2999
11954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	1/1/2013	12/31/2999
11970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of tissue expander with permanent implant	1/1/2013	12/31/2999
11971	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of tissue expander without insertion of implant	1/1/2013	12/31/2999
11980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	1/1/2013	12/31/2999
11981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)	2/12/2015	12/31/2999
11982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, non-biodegradable drug delivery implant	1/1/2026	12/31/2999
11983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal with reinsertion, non-biodegradable drug delivery implant	2/12/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	1/1/2025	12/31/2999
15012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less; each additional 25 sq cm or part therof (List separately in addition to code for primary procedure)	1/1/2025	12/31/2999
15013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin	1/1/2025	12/31/2999
84999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemistry procedure	6/20/2014	12/31/2999
15014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part therof (List separately in addition to code for primary procedure)	1/1/2025	12/31/2999
85999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted hematology and coagulation procedure	1/1/1950	12/31/2999
15015	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms legs; first 480 sq cm or less	1/1/2025	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	4/1/2023	12/31/2999
15274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
86486	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Skin test; unlisted antigen, each	4/16/2015	12/31/2999
15275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	4/1/2023	12/31/2999
15276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
86849	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immunology procedure	1/1/1950	12/31/2999
15277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	4/1/2023	12/31/2999
15278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	4/1/2023	12/31/2999
15758	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Free fascial flap with microvascular anastomosis	10/1/2015	12/31/2999
86999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted transfusion medicine procedure	4/16/2015	12/31/2999
15769	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
87797	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	10/24/2019	12/31/2999
15771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	1/1/2020	12/31/2999
87798	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism	10/24/2019	12/31/2999
15772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	1/1/2020	12/31/2999
15773	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	1/1/2020	12/31/2999
15774	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	1/1/2020	12/31/2999
87799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; 1 to 15 punch grafts	1/1/2013	12/31/2999
87899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	10/24/2019	12/31/2999
15776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Punch graft for hair transplant; more than 15 punch grafts	1/1/2013	12/31/2999
87999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted microbiology procedure	4/16/2015	12/31/2999
15780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	1/1/2013	12/31/2999
15781	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; segmental, face	1/1/2013	12/31/2999
15782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; regional, other than face	1/1/2013	12/31/2999
15783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermabrasion; superficial, any site (eg, tattoo removal)	1/1/2013	12/31/2999
15788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, facial; epidermal	1/1/2013	12/31/2999
15789	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, facial; dermal	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15792	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, nonfacial; epidermal	1/1/2013	12/31/2999
15793	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemical peel, nonfacial; dermal	1/1/2013	12/31/2999
15820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, lower eyelid;	1/1/2013	12/31/2999
15821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, lower eyelid; with extensive herniated fat pad	1/1/2013	12/31/2999
15822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, upper eyelid;	1/1/2013	12/31/2999
15823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	1/1/2013	12/31/2999
15824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; forehead	1/1/2013	12/31/2999
15825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	1/1/2013	12/31/2999
15826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; glabellar frown lines	1/1/2013	12/31/2999
15828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; cheek, chin, and neck	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted necropsy (autopsy) procedure	4/16/2015	12/31/2999
15829	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	1/1/2013	12/31/2999
15830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	1/1/2013	12/31/2999
88199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytopathology procedure	4/16/2015	12/31/2999
15832	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	1/1/2013	12/31/2999
88299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cytogenetic study	10/24/2014	12/31/2999
15833	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	1/1/2013	12/31/2999
15834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	1/1/2013	12/31/2999
88399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted surgical pathology procedure	4/16/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	1/1/2013	12/31/2999
88749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted in vivo (eg, transcutaneous) laboratory service	1/1/2011	12/31/2999
15836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	1/1/2013	12/31/2999
89240	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted miscellaneous pathology test	1/1/1950	12/31/2999
15837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	1/1/2013	12/31/2999
15838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	1/1/2013	12/31/2999
15839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	1/1/2013	12/31/2999
15847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
15876	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; head and neck	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
15877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; trunk	1/1/2013	12/31/2999
15878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; upper extremity	1/1/2013	12/31/2999
15879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suction assisted lipectomy; lower extremity	1/1/2013	12/31/2999
17106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	1/1/2013	12/31/2999
17107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	1/1/2013	12/31/2999
17108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	1/1/2013	12/31/2999
17380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrolysis epilation, each 30 minutes	1/1/2013	12/31/2999
89398	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted reproductive medicine laboratory procedure	1/1/2010	12/31/2999
90399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted immune globulin	1/1/1950	12/31/2999
19300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy for gynecomastia	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19303	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastectomy, simple, complete	1/1/2013	12/31/2999
19316	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mastopexy	1/1/2013	12/31/2999
19318	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Breast reduction	1/1/2013	12/31/2999
19325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Breast augmentation with implant	1/1/2013	12/31/2999
90749	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted vaccine/toxoid	1/1/1950	12/31/2999
19328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of intact breast implant	1/1/2013	12/31/2999
19330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	1/1/2013	12/31/2999
19340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of breast implant on same day of mastectomy (ie, immediate)	1/1/2013	12/31/2999
19342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of breast implant on separate day from mastectomy	1/1/2013	12/31/2999
19350	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nipple/areola reconstruction	6/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Correction of inverted nipples	1/1/2013	12/31/2999
90899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted psychiatric service or procedure	1/1/1950	12/31/2999
19357	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	6/1/2017	12/31/2999
90999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted dialysis procedure, inpatient or outpatient	1/1/1950	12/31/2999
19370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	1/1/2013	12/31/2999
19371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	1/1/2013	12/31/2999
19380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	9/15/2016	12/31/2999
19396	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of moulage for custom breast implant	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
19499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, breast	11/1/2017	12/31/2999
20560	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	12/1/2020	12/31/2999
20561	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Needle insertion(s) without injection(s); 3 or more muscles	12/1/2020	12/31/2999
20932	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	1/1/2019	12/31/2999
20933	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	1/1/2019	12/31/2999
20934	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	1/1/2019	12/31/2999
20974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
20975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulation to aid bone healing; invasive (operative)	1/1/2013	12/31/2999
20979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	1/1/2013	12/31/2999
91299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted diagnostic gastroenterology procedure	1/1/1950	12/31/2999
20982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	1/1/2013	12/31/2999
20985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
21010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrotomy, temporomandibular joint	9/15/2016	12/31/2999
92499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ophthalmological service or procedure	1/1/1950	12/31/2999
21050	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Condylectomy, temporomandibular joint (separate procedure)	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21060	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	9/15/2016	12/31/2999
21070	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Coronoidectomy (separate procedure)	9/15/2016	12/31/2999
21073	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	1/1/2013	12/31/2999
21083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation; palatal lift prosthesis	1/1/2013	12/31/2999
21085	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Impression and custom preparation; oral surgical splint	1/1/2013	12/31/2999
21110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	9/15/2016	12/31/2999
21120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; augmentation (autograft, allograft, prosthetic material)	1/1/2013	12/31/2999
21121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomy, single piece	1/1/2013	12/31/2999
21122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	1/1/2013	12/31/2999
21123	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Augmentation, mandibular body or angle; prosthetic material	1/1/2013	12/31/2999
21127	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	1/1/2013	12/31/2999
21141	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	1/1/2013	12/31/2999
21142	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	1/1/2013	12/31/2999
21143	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	1/1/2013	12/31/2999
21145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	1/1/2013	12/31/2999
21146	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	1/1/2013	12/31/2999
21147	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	1/1/2013	12/31/2999
21151	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	1/1/2013	12/31/2999
21154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	1/1/2013	12/31/2999
21155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	1/1/2013	12/31/2999
21159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	1/1/2013	12/31/2999
21160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	1/1/2013	12/31/2999
21188	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	1/1/2013	12/31/2999
21193	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21194	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	1/1/2013	12/31/2999
21195	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	1/1/2013	12/31/2999
21196	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	1/1/2013	12/31/2999
21198	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteotomy, mandible, segmental;	1/1/2013	12/31/2999
21199	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteotomy, mandible, segmental; with genioglossus advancement	1/1/2013	12/31/2999
21206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	1/1/2013	12/31/2999
21208	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	1/1/2013	12/31/2999
21209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteoplasty, facial bones; reduction	1/1/2013	12/31/2999
21210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	1/1/2013	12/31/2999
21215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Graft, bone; mandible (includes obtaining graft)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	9/1/2016	12/31/2999
21242	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, temporomandibular joint, with allograft	9/15/2016	12/31/2999
21243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	9/15/2016	12/31/2999
21244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	1/1/2013	12/31/2999
21245	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, subperiosteal implant; partial	1/1/2013	12/31/2999
92700	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted otorhinolaryngological service or procedure	1/1/1950	12/31/2999
21246	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reconstruction of mandible or maxilla, subperiosteal implant; complete	1/1/2013	12/31/2999
21282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lateral canthopexy	8/1/2021	12/31/2999
21480	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Closed treatment of temporomandibular dislocation; initial or subsequent	9/15/2016	12/31/2999
21485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
21490	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open treatment of temporomandibular dislocation	9/15/2016	12/31/2999
21685	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hyoid myotomy and suspension	1/1/2013	12/31/2999
22505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation of spine requiring anesthesia, any region	4/1/2020	12/31/2999
22510	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	1/1/2015	12/31/2999
22511	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	1/1/2015	12/31/2999
22512	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22513	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	1/1/2015	12/31/2999
22514	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	1/1/2015	12/31/2999
22515	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	1/1/2015	12/31/2999
22526	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22527	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
22548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	5/1/2021	12/31/2999
22551	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	5/1/2021	12/31/2999
22552	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	5/1/2021	12/31/2999
22554	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	5/1/2021	12/31/2999
22586	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
22590	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, posterior technique, craniocervical (occiput-C2)	5/1/2021	12/31/2999
22595	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, posterior technique, atlas-axis (C1-C2)	5/1/2021	12/31/2999
22600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	5/1/2021	12/31/2999
22836	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	5/15/2024	12/31/2999
22837	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	5/15/2024	12/31/2999
22838	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	5/15/2024	12/31/2999
93799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted cardiovascular service or procedure	1/1/1950	12/31/2999
22867	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted noninvasive vascular diagnostic study	1/1/2012	12/31/2999
22868	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
22869	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	1/1/2023	12/31/2999
22870	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	1/1/2023	12/31/2999
23929	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, shoulder	11/1/2017	12/31/2999
94799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted pulmonary service or procedure	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
24300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation, elbow, under anesthesia	6/15/2015	12/31/2999
95199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted allergy/clinical immunologic service or procedure	1/1/1950	12/31/2999
27096	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	9/15/2020	12/31/2999
27275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manipulation, hip joint, requiring general anesthesia	1/1/2013	12/31/2999
27278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthrodesis, sacroiliac joint, percutaneous, or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral placement of intra-articular device(s), without cortical piercing	5/15/2024	12/31/2999
27279	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	placement of transarticular device(s) and/or intra-articular device(s) piercing the lateral or medial cortices of the ilium and the lateral cortex of the sacrum	1/1/2017	12/31/2999
27299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, pelvis or hip joint	6/1/2017	12/31/2999
27415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteochondral allograft, knee, open	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
27416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])	1/1/2013	12/31/2999
27702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, ankle; with implant (total ankle)	1/1/2013	12/31/2999
27703	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroplasty, ankle; revision, total ankle	1/1/2013	12/31/2999
27704	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ankle implant	1/1/2013	12/31/2999
28446	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open osteochondral autograft, talus (includes obtaining graft[s])	2/1/2018	12/31/2999
28890	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	2/15/2015	12/31/2999
95999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted neurological or neuromuscular diagnostic procedure	1/1/1950	12/31/2999
29800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	9/15/2016	12/31/2999
29804	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, temporomandibular joint, surgical	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
29862	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	1/1/2022	12/31/2999
29866	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	1/1/2013	12/31/2999
29867	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	1/1/2013	12/31/2999
29868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral	1/1/2013	12/31/2999
29914	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	1/1/2013	12/31/2999
29915	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	1/1/2013	12/31/2999
29916	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, hip, surgical; with labral repair	1/1/2013	12/31/2999
29999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, arthroscopy	11/1/2017	12/31/2999
30117	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision or destruction (eg, laser), intranasal lesion; internal approach	6/15/2024	12/31/2999
30120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision or surgical planing of skin of nose for rhinophyma	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
30130	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excision inferior turbinate, partial or complete, any method	9/15/2024	12/31/2999
30140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucous resection inferior turbinate, partial or complete, any method	9/15/2024	12/31/2999
30150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinectomy; partial	1/1/2013	12/31/2999
30400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	1/1/2013	12/31/2999
30410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	1/1/2013	12/31/2999
30420	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, primary; including major septal repair	1/1/2013	12/31/2999
30430	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	1/1/2013	12/31/2999
30435	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	1/1/2013	12/31/2999
30450	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	1/1/2013	12/31/2999
30468	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
30469	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	1/1/2023	12/31/2999
30520	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	9/15/2024	12/31/2999
96379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	1/1/2009	12/31/2999
31242	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	5/15/2024	12/31/2999
31243	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	5/15/2024	12/31/2999
31295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	5/1/2018	12/31/2999
31296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	5/1/2018	12/31/2999
31297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	5/1/2018	12/31/2999
31298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted chemotherapy procedure	1/1/1950	12/31/2999
31634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	7/15/2020	12/31/2999
96999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special dermatological service or procedure	1/1/1950	12/31/2999
97039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted modality (specify type and time if constant attendance)	1/1/1950	12/31/2999
31660	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	5/15/2025	12/31/2999
97139	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted therapeutic procedure (specify)	1/1/1950	12/31/2999
31661	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	5/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
32553	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	10/3/2016	12/31/2999
32850	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor pneumonectomy(s) (including cold preservation), from cadaver donor	1/1/2013	12/31/2999
32851	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lung transplant, single; without cardiopulmonary bypass	1/1/2013	12/31/2999
32852	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lung transplant, single; with cardiopulmonary bypass	1/1/2013	12/31/2999
32853	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	1/1/2013	12/31/2999
32854	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	1/1/2013	12/31/2999
32855	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral	1/1/2013	12/31/2999
32856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
32998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	1/1/2013	12/31/2999
97799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted physical medicine/rehabilitation service or procedure	1/1/1950	12/31/2999
33202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)	1/1/2013	12/31/2999
33203	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy)	1/1/2013	12/31/2999
33211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	11/1/2016	12/31/2999
33213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacemaker pulse generator only; with existing dual leads	1/1/2013	12/31/2999
33216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	1/1/2013	12/31/2999
33217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	1/1/2013	12/31/2999
33218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	8/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	8/1/2021	12/31/2999
33223	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Relocation of skin pocket for implantable defibrillator	8/1/2021	12/31/2999
33224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	1/1/2013	12/31/2999
33225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
33230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of implantable defibrillator pulse generator only; with existing dual leads	1/1/2013	12/31/2999
33231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	1/1/2013	12/31/2999
33240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of implantable defibrillator pulse generator only; with existing single lead	1/1/2013	12/31/2999
33241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of implantable defibrillator pulse generator only	8/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy	8/1/2021	12/31/2999
33244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	8/1/2021	12/31/2999
33249	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	1/1/2013	12/31/2999
33262	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	8/1/2021	12/31/2999
33263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	8/1/2021	12/31/2999
33264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	8/1/2021	12/31/2999
33267	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	1/1/2022	12/31/2999
33269	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	1/1/2022	12/31/2999
33270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	1/1/2015	12/31/2999
33271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of subcutaneous implantable defibrillator electrode	1/1/2015	12/31/2999
33272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of subcutaneous implantable defibrillator electrode	8/1/2021	12/31/2999
33273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	8/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	5/15/2024	12/31/2999
33277	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	5/15/2024	12/31/2999
33278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	5/15/2024	12/31/2999
99050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	1/1/1950	12/31/2999
33279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	5/15/2024	12/31/2999
99056	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33280	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	5/15/2024	12/31/2999
99058	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	1/1/1950	12/31/2999
33281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repositioning of phrenic nerve stimulator transvenous lead(s)	5/15/2024	12/31/2999
99070	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	1/1/1950	12/31/2999
33285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion, subcutaneous cardiac rhythm monitor, including programming	1/1/2019	12/31/2999
33286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, subcutaneous cardiac rhythm monitor	1/1/2019	12/31/2999
33287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99075	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Medical testimony	1/1/1950	12/31/2999
33288	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	5/15/2024	12/31/2999
33289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	9/1/2020	12/31/2999
33340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99078	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	1/1/1950	12/31/2999
99080	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	1/1/1950	12/31/2999
99082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unusual travel (eg, transportation and escort of patient)	1/1/1950	12/31/2999
99199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted special service, procedure or report	4/16/2015	12/31/2999
99429	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted preventive medicine service	1/1/1950	12/31/2999
33370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, Dor procedures)	9/1/2020	12/31/2999
33882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stent graft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation	1/1/2026	12/31/2999
33897	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta	1/1/2022	12/31/2999
99499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted evaluation and management service	1/1/1950	12/31/2999
33927	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	1/1/2018	12/31/2999
33928	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of total replacement heart system (artificial heart)	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33929	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	1/1/2018	12/31/2999
33930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor cardiectomy-pneumonectomy (including cold preservation)	12/15/2017	12/31/2999
33933	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation	12/15/2017	12/31/2999
33935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heart-lung transplant with recipient cardiectomy-pneumonectomy	12/15/2017	12/31/2999
33940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor cardiectomy (including cold preservation)	12/15/2017	12/31/2999
33944	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation	12/15/2017	12/31/2999
33945	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heart transplant, with or without recipient cardiectomy	12/15/2017	12/31/2999
33975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device; extracorporeal, single ventricle	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device; extracorporeal, biventricular	1/1/2013	12/31/2999
33977	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ventricular assist device; extracorporeal, single ventricle	1/1/2013	12/31/2999
33978	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ventricular assist device; extracorporeal, biventricular	1/1/2013	12/31/2999
33979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	1/1/2013	12/31/2999
33980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of ventricular assist device, implantable intracorporeal, single ventricle	1/1/2013	12/31/2999
33981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	1/1/2013	12/31/2999
33982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	1/1/2013	12/31/2999
33983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	1/1/2013	12/31/2999
33990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
33991	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	1/1/2013	12/31/2999
33992	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	1/1/2013	12/31/2999
33993	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	1/1/2013	12/31/2999
33995	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	1/1/2021	12/31/2999
33997	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	1/1/2021	12/31/2999
99600	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted home visit service or procedure	1/1/1950	12/31/2999
33999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, cardiac surgery	11/1/2017	12/31/2999
35602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bypass graft, with other than vein; carotid-contralateral carotid	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36465	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	1/1/2018	12/31/2999
36466	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	1/1/2018	12/31/2999
36468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	1/1/2013	12/31/2999
36470	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; single incompetent vein (other than telangiectasia)	1/1/2013	12/31/2999
36471	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1/1/2013	12/31/2999
36473	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36474	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	12/1/2020	12/31/2999
36475	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	1/1/2013	12/31/2999
0101T	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	7/1/2005	12/31/2999
36476	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
36478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36479	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
36482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	9/1/2019	12/31/2999
36483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	9/1/2019	12/31/2999
36511	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis; for white blood cells	12/15/2020	12/31/2999
36516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
36522	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photopheresis, extracorporeal	1/1/2013	12/31/2999
37215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	1/1/2013	12/31/2999
37216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	1/1/2013	12/31/2999
37217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	10/15/2014	12/31/2999
37218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	1/1/2014	12/31/2999
37242	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	1/1/2014	12/31/2999
37243	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	1/1/2014	12/31/2999
37244	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	1/1/2014	12/31/2999

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

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

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

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

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

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

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

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

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

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

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37281	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) lesion, initial vessel	1/1/2026	12/31/2999
37288	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
37700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	1/1/2013	12/31/2999
37718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and stripping, short saphenous vein	1/1/2013	12/31/2999
37722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	1/1/2013	12/31/2999
37735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	1/1/2013	12/31/2999
37760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
37761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	1/1/2013	12/31/2999
37765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	1/1/2013	12/31/2999
37766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	1/1/2013	12/31/2999
37780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	1/1/2013	12/31/2999
37785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	1/1/2013	12/31/2999
37788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile revascularization, artery, with or without vein graft	1/1/2013	12/31/2999
37790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile venous occlusive procedure	1/1/2013	12/31/2999
38204	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	1/1/2013	12/31/2999
38205	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	1/1/2013	12/31/2999
38207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38208	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor	1/1/2013	12/31/2999
38209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor	1/1/2013	12/31/2999
38210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion	1/1/2013	12/31/2999
38211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion	1/1/2013	12/31/2999
38212	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; red blood cell removal	1/1/2013	12/31/2999
38213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; platelet depletion	1/1/2013	12/31/2999
38214	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion	1/1/2013	12/31/2999
38215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer	1/1/2013	12/31/2999
38225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
38226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)	1/1/2025	12/31/2999
38227	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	1/1/2025	12/31/2999
38228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cells for administration, autologous	1/1/2025	12/31/2999
38232	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bone marrow harvesting for transplantation; autologous	1/1/2013	12/31/2999
38240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	1/1/2013	12/31/2999
38308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lymphangiotomy or other operations on lymphatic channels	4/15/2016	12/31/2999
41120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Glossectomy; less than one-half tongue	3/15/2014	12/31/2999
41512	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tongue base suspension, permanent suture technique	1/1/2013	12/31/2999
41530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	4/1/2024	12/31/2999
41872	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gingivoplasty, each quadrant (specify)	2/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
42145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	1/1/2013	12/31/2999
42950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharyngoplasty (plastic or reconstructive operation on pharynx)	3/15/2024	12/31/2999
43192	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	11/1/2014	12/31/2999
43201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1/1/2013	12/31/2999
43206	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagoscopy, flexible, transoral; with optical endomicroscopy	2/15/2015	12/31/2999
43210	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	7/15/2016	12/31/2999
43229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	2/1/2022	12/31/2999
43236	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1/1/2013	12/31/2999
43252	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43253	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	1/1/2014	12/31/2999
43257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	1/1/2013	12/31/2999
43270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	2/1/2022	12/31/2999
43284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	1/1/2017	12/31/2999
43285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of esophageal sphincter augmentation device	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted laparoscopy procedure, esophagus	6/1/2017	12/31/2999
43290	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	1/1/2023	12/31/2999
43291	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	1/1/2023	12/31/2999
43497	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	1/1/2022	12/31/2999
43632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with gastrojejunostomy	6/1/2023	12/31/2999
43633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	1/1/2013	12/31/2999
43634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrectomy, partial, distal; with formation of intestinal pouch	1/1/2026	12/31/2999
43644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	1/1/2013	12/31/2999
43645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43647	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	1/1/2013	12/31/2999
43648	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	1/1/2013	12/31/2999
43770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	1/1/2013	12/31/2999
43771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	1/1/2013	12/31/2999
43772	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	1/1/2013	12/31/2999
43773	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	1/1/2013	12/31/2999
43774	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	1/1/2013	12/31/2999
43775	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	1/1/2013	12/31/2999
43842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	1/1/2013	12/31/2999
43845	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	1/1/2013	12/31/2999
43846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	1/1/2013	12/31/2999
43847	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	4/1/2020	12/31/2999
43848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	1/1/2013	12/31/2999
43881	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	1/1/2013	12/31/2999
43882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of gastric neurostimulator electrodes, antrum, open	1/1/2013	12/31/2999
43886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; revision of subcutaneous port component only	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
43887	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; removal of subcutaneous port component only	1/1/2013	12/31/2999
43888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	1/1/2013	12/31/2999
43889	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed	1/1/2026	12/31/2999
44132	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor enterectomy (including cold preservation), open; from cadaver donor	11/1/2016	12/31/2999
44133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor enterectomy (including cold preservation), open; partial, from living donor	11/1/2016	12/31/2999
44135	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intestinal allotransplantation; from cadaver donor	11/1/2016	12/31/2999
44136	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intestinal allotransplantation; from living donor	11/1/2016	12/31/2999
44137	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of transplanted intestinal allograft, complete	11/1/2016	12/31/2999
44705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation of fecal microbiota for instillation, including assessment of donor specimen	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
44715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein	11/1/2016	12/31/2999
44720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each	11/1/2016	12/31/2999
44721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each	11/1/2016	12/31/2999
46707	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	2/15/2015	12/31/2999
47133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor hepatectomy (including cold preservation), from cadaver donor	11/1/2016	12/31/2999
47135	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	11/1/2016	12/31/2999
47140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)	11/1/2016	12/31/2999
47141	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)	11/1/2016	12/31/2999
47142	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	11/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47143	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split	11/1/2016	12/31/2999
47144	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (ie, left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])	11/1/2016	12/31/2999
47145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into 2 partial liver grafts (ie, left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])	11/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
47146	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each	11/1/2016	12/31/2999
47147	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each	11/1/2016	12/31/2999
47370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	1/1/2013	12/31/2999
47371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	9/1/2020	12/31/2999
47380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, open, of 1 or more liver tumor(s); radiofrequency	1/1/2013	12/31/2999
47381	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, open, of 1 or more liver tumor(s); cryosurgical	9/1/2020	12/31/2999
47382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	1/1/2013	12/31/2999
47383	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	9/1/2020	12/31/2999
47384	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	1/1/2026	12/31/2999
48160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
48550	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	1/1/2013	12/31/2999
48551	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery	1/1/2013	12/31/2999
48552	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each	1/1/2013	12/31/2999
48554	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation of pancreatic allograft	1/1/2013	12/31/2999
48556	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of transplanted pancreatic allograft	1/1/2013	12/31/2999
49411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	10/3/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
49412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	10/3/2016	12/31/2999
50300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral	11/1/2016	12/31/2999
50320	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor nephrectomy (including cold preservation); open, from living donor	11/1/2016	12/31/2999
50323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary	11/1/2016	12/31/2999
50325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary	11/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
50327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each	11/1/2016	12/31/2999
50328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each	11/1/2016	12/31/2999
50329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each	11/1/2016	12/31/2999
50340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Recipient nephrectomy (separate procedure)	11/1/2016	12/31/2999
50360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renal allotransplantation, implantation of graft; without recipient nephrectomy	10/1/2016	12/31/2999
50365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renal allotransplantation, implantation of graft; with recipient nephrectomy	11/1/2016	12/31/2999
50370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of transplanted renal allograft	11/1/2016	12/31/2999
50547	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	11/1/2016	12/31/2999
50592	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
51715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	1/1/2013	12/31/2999
51721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement of an endorectal cooling device, when performed	1/1/2025	12/31/2999
52284	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	5/15/2024	12/31/2999
52287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	1/1/2013	12/31/2999
52327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	6/1/2017	12/31/2999
52441	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	12/1/2015	12/31/2999
52442	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
52443	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed	1/1/2026	12/31/2999
53451	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	10/1/2024	12/31/2999
53452	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	10/1/2024	12/31/2999
53453	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; removal, each balloon	10/1/2024	12/31/2999
53454	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	10/1/2024	12/31/2999
53855	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Insertion of a temporary prostatic urethral stent, including urethral measurement	5/15/2024	12/31/2999
53860	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
53865	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy with Insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	1/1/2025	12/31/2999
53866	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	1/1/2025	12/31/2999
54125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputation of penis; complete	1/1/2013	12/31/2999
54200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for Peyronie disease;	1/1/2013	12/31/2999
54205	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for Peyronie disease; with surgical exposure of plaque	1/1/2013	12/31/2999
54235	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)	1/1/2013	12/31/2999
54240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile plethysmography	9/1/2020	12/31/2999
54360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Plastic operation on penis to correct angulation	1/1/2013	12/31/2999
54400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; non-inflatable (semi-rigid)	1/1/2013	12/31/2999
54401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of penile prosthesis; inflatable (self-contained)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	1/1/2013	12/31/2999
54406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	1/1/2013	12/31/2999
54408	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of component(s) of a multi-component, inflatable penile prosthesis	1/1/2013	12/31/2999
54410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	1/1/2013	12/31/2999
54411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	1/1/2013	12/31/2999
54415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	1/1/2013	12/31/2999
54416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
54417	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	1/1/2013	12/31/2999
54660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of testicular prosthesis (separate procedure)	1/1/2013	12/31/2999
54900	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral	1/1/2013	12/31/2999
54901	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral	1/1/2013	12/31/2999
55400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vasovasostomy, vasovasorrhaphy	1/1/2013	12/31/2999
55706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	1/1/2013	12/31/2999
55870	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electroejaculation	1/1/2013	12/31/2999
55873	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)	1/1/2013	12/31/2999
55876	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	10/3/2016	12/31/2999
55877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
55880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	1/1/2021	12/31/2999
55881	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation	1/1/2025	12/31/2999
55882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed	1/1/2025	12/31/2999
55970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; male to female	1/1/2013	12/31/2999
55980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intersex surgery; female to male	1/1/2013	12/31/2999
56700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Partial hymenectomy or revision of hymenal ring	10/1/2022	12/31/2999
56805	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Clitoroplasty for intersex state	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
56810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	1/1/2013	12/31/2999
57291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; without graft	1/1/2013	12/31/2999
57292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Construction of artificial vagina; with graft	1/1/2013	12/31/2999
57295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft; vaginal approach	1/1/2013	12/31/2999
57296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	1/1/2013	12/31/2999
57335	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vaginoplasty for intersex state	1/1/2013	12/31/2999
57426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	1/1/2013	12/31/2999
58580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	1/1/2024	12/31/2999
58674	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	1/1/2017	12/31/2999
58750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tubotubal anastomosis	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
58752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tubouterine implantation	1/1/2013	12/31/2999
58970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Follicle puncture for oocyte retrieval, any method	11/1/2015	12/31/2999
58974	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Embryo transfer, intrauterine	11/1/2015	12/31/2999
58976	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gamete, zygote, or embryo intrafallopian transfer, any method	11/1/2015	12/31/2999
59072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal umbilical cord occlusion, including ultrasound guidance	3/1/2021	12/31/2999
59074	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	3/1/2021	12/31/2999
59076	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal shunt placement, including ultrasound guidance	1/1/2013	12/31/2999
59897	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	6/1/2017	12/31/2999
60660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	1/1/2025	12/31/2999
60661	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ablation of 1 or more thyroid nodule(s), additional lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)	1/1/2025	12/31/2999
60699	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, endocrine system	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; central nervous system (intracranial, spinal cord)	1/1/2025	12/31/2999
61630	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	12/1/2020	12/31/2999
61635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	9/1/2020	12/31/2999
61645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	1/1/2016	12/31/2999
61650	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	1/1/2016	12/31/2999
61715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target intracranial, including stereotactic navigation and frame placement, when performed	1/1/2025	12/31/2999
61736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	1/1/2022	12/31/2999
61737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	1/1/2022	12/31/2999
61850	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	1/1/2013	12/31/2999
61860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
61880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of intracranial neurostimulator electrodes	1/1/2013	12/31/2999
61885	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	1/1/2013	12/31/2999
61888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of cranial neurostimulator pulse generator or receiver	1/1/2013	12/31/2999
61889	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	1/1/2024	12/31/2999
61891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	1/1/2024	12/31/2999
61892	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	1/1/2024	12/31/2999
62263	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	8/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
62264	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	8/1/2022	12/31/2999
62268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous aspiration, spinal cord cyst or syrinx	2/1/2025	12/31/2999
62287	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle -based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	1/1/2023	12/31/2999
62330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar	1/1/2026	12/31/2999
62331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
62380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	4/1/2020	12/31/2999
63032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure)	1/1/2026	3/31/2026
63052	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	1/1/2022	12/31/2999
63053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure)	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
63266	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	2/1/2025	12/31/2999
63268	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	2/1/2025	12/31/2999
63271	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic	2/1/2025	12/31/2999
63273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; sacral	2/1/2025	12/31/2999
63276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic	2/1/2025	12/31/2999
63278	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, sacral	2/1/2025	12/31/2999
63295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	2/1/2025	12/31/2999
64451	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	1/1/2026	12/31/2999
64505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, anesthetic agent; sphenopalatine ganglion	9/1/2020	12/31/2999
64553	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous implantation of neurostimulator electrode array; cranial nerve	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64555	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	5/15/2025	12/31/2999
64561	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	1/1/2013	12/31/2999
64567	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	1/1/2026	12/31/2999
64568	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	1/1/2013	12/31/2999
64569	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	11/1/2016	12/31/2999
64570	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	11/1/2016	12/31/2999
64581	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)	1/1/2013	12/31/2999
64582	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64583	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	1/1/2022	12/31/2999
64584	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	1/1/2022	12/31/2999
64596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	1/1/2024	12/31/2999
64597	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999
64598	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	1/1/2024	12/31/2999
64615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	1/1/2013	12/31/2999
64620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, intercostal nerve	2/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	9/1/2020	12/31/2999
64625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	1/1/2020	12/31/2999
64628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	12/1/2025	12/31/2999
64629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	12/1/2025	12/31/2999
64633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	6/15/2016	12/31/2999
64634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	6/15/2016	12/31/2999
64635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	6/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64636	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	6/15/2016	12/31/2999
64640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Destruction by neurolytic agent; other peripheral nerve or branch	6/1/2019	12/31/2999
64654	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (ie, total system), and intraoperative interrogation and programming	1/1/2026	12/31/2999
64655	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only	1/1/2026	12/31/2999
64656	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only	1/1/2026	12/31/2999
64657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator	1/1/2026	12/31/2999
64658	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; lead only	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
64659	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of baroreflex activation therapy (BAT) modulation system; pulse generator only	1/1/2026	12/31/2999
64716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuroplasty and/or transposition; cranial nerve (specify)	1/1/2013	12/31/2999
64732	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transection or avulsion of; supraorbital nerve	1/1/2013	12/31/2999
64734	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transection or avulsion of; infraorbital nerve	1/1/2013	12/31/2999
64771	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transection or avulsion of other cranial nerve, extradural	1/1/2013	12/31/2999
65756	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoplasty (corneal transplant); endothelial	1/1/2013	12/31/2999
65757	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
65760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Keratomileusis	1/1/2021	12/31/2999
65765	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Keratophakia	1/1/2021	12/31/2999
65770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Keratoprosthesis	1/1/2013	12/31/2999
65771	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Radial keratotomy	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
65778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of amniotic membrane on the ocular surface; without sutures	5/1/2020	12/31/2999
65779	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement of amniotic membrane on the ocular surface; single layer, sutured	1/1/2013	12/31/2999
65780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	1/1/2013	12/31/2999
66174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent	1/1/2013	12/31/2999
66175	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent	1/1/2013	12/31/2999
66179	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	1/1/2015	12/31/2999
66180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	3/1/2018	12/31/2999
66183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	1/1/2014	12/31/2999
66184	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	1/1/2015	12/31/2999
66185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	3/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
66989	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	1/1/2022	12/31/2999
66991	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	1/1/2022	12/31/2999
67027	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravitreal injection of a pharmacologic agent (separate procedure)	1/1/2013	12/31/2999
67345	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chemodenervation of extraocular muscle	1/1/2013	12/31/2999
67516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Suprachoroidal space injection of pharmacologic agent (separate procedure)	5/1/2024	12/31/2999
67900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	1/1/2013	12/31/2999
67901	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	1/1/2013	12/31/2999
67902	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	1/1/2013	12/31/2999
67903	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	1/1/2013	12/31/2999
67904	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	1/1/2013	12/31/2999
67906	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	1/1/2013	12/31/2999
67908	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
67909	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reduction of overcorrection of ptosis	1/1/2013	12/31/2999
67911	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Correction of lid retraction	1/1/2013	12/31/2999
67912	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	1/1/2013	12/31/2999
67916	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of ectropion; excision tarsal wedge	1/1/2013	12/31/2999
67917	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of ectropion; extensive (eg, tarsal strip operations)	1/1/2013	12/31/2999
67923	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of entropion; excision tarsal wedge	1/1/2013	12/31/2999
67924	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	1/1/2013	12/31/2999
67950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Canthoplasty (reconstruction of canthus)	1/1/2026	12/31/2999
68841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each	1/1/2022	12/31/2999
69090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ear piercing	4/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Otoplasty, protruding ear, with or without size reduction	1/1/2013	12/31/2999
69705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	1/1/2021	12/31/2999
69706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	1/1/2021	12/31/2999
69710	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	1/1/2013	12/31/2999
69711	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	1/1/2013	12/31/2999
69714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	1/1/2013	12/31/2999
69716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2022	12/31/2999
69717	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69719	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2022	12/31/2999
69726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor	1/1/2022	12/31/2999
69727	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2022	12/31/2999
69728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2023	12/31/2999
69729	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
69730	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	1/1/2023	12/31/2999
69930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cochlear device implantation, with or without mastoidectomy	1/1/2013	12/31/2999
75577	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional	1/1/2026	12/31/2999
75894	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	1/1/2013	12/31/2999
76120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cineradiography/videoradiography, except where specifically included	1/1/2013	12/31/2999
76125	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
76940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
76948	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	11/1/2015	12/31/2999
77013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	1/1/2013	12/31/2999
77022	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	2/1/2022	12/31/2999
77262	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic radiology treatment planning; intermediate	1/1/2013	12/31/2999
77263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic radiology treatment planning; complex	1/1/2013	12/31/2999
77293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Respiratory motion management simulation (List separately in addition to code for primary procedure)	1/1/2014	12/31/2999
77299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, therapeutic radiology clinical treatment planning	1/1/2013	12/31/2999
77332	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Treatment devices, design and construction; simple (simple block, simple bolus)	1/1/2013	12/31/2999
77333	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)	1/1/2013	12/31/2999
77334	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
77399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	10/3/2016	12/31/2999
77499	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, therapeutic radiology treatment management	10/3/2016	12/31/2999
77799	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted procedure, clinical brachytherapy	10/3/2016	12/31/2999
78429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	1/1/2020	12/31/2999
78430	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	1/1/2020	12/31/2999
78431	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78432	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	1/1/2020	12/31/2999
78433	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	1/1/2020	12/31/2999
78434	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	1/1/2020	12/31/2999
78459	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	1/1/2013	12/31/2999
78491	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
78492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	1/1/2013	12/31/2999
78835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	1/1/2020	12/31/2999
79445	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiopharmaceutical therapy, by intra-arterial particulate administration	4/15/2021	12/31/2999
80145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adalimumab	9/1/2020	12/31/2999
80230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infliximab	9/1/2020	12/31/2999
80280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vedolizumab	9/1/2020	12/31/2999
81105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81106	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)	1/1/2018	12/31/2999
81107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)	1/1/2018	12/31/2999
81108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)	1/1/2018	12/31/2999
81109	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b [K505E])	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)	1/1/2018	12/31/2999
81111	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)	1/1/2018	12/31/2999
81112	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)	1/1/2018	12/31/2999
81161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	1/1/2013	12/31/2999
81206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	1/1/2013	12/31/2999
81207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	1/1/2013	12/31/2999
81354	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of structural and copy number variants, optical genome mapping (OGM)	1/1/2026	3/31/2026
81500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	4/1/2021	12/31/2999
81507	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	1/1/2014	12/31/2999
81524	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (central nervous system tumor), DNA methylation analysis of at least 10,000 methylation sites, utilizing DNA extracted from formalin-fixed tumor tissue, algorithm(s) reported as probability of matching a reference tumor family and class, and MGMT (O-6?methylguanine-DNA methyltransferase) promoter methylation status, if performed	1/1/2026	3/31/2026
81538	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	4/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
81560	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation medicine (allograft rejection, pediatric liver and small bowel), measurement of donor and third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	1/1/2022	12/31/2999
82523	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Collagen cross links, any method	2/15/2015	12/31/2999
83695	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein (a)	2/15/2015	12/31/2999
83698	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	2/15/2015	12/31/2999
83701	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)	2/15/2015	12/31/2999
83704	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed	2/15/2015	12/31/2999
83722	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Lipoprotein, direct measurement; small dense LDL cholesterol	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
83937	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Osteocalcin (bone g1a protein)	2/15/2015	12/31/2999
84112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen	8/15/2015	12/31/2999
86001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allergen specific IgG quantitative or semiquantitative, each allergen	12/1/2020	12/31/2999
86294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Immunoassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen)	1/1/2013	12/31/2999
86328	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	6/1/2023	12/31/2999
86343	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Leukocyte histamine release test (LHR)	12/1/2020	12/31/2999
86408	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen	6/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
86409	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer	6/1/2023	12/31/2999
86413	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative	6/1/2023	12/31/2999
86769	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])	6/1/2023	12/31/2999
86910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood typing, for paternity testing, per individual; ABO, Rh and MN	1/1/2013	12/31/2999
86911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood typing, for paternity testing, per individual; each additional antigen system	1/1/2013	12/31/2999
86950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leukocyte transfusion	1/1/2013	12/31/2999
88000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; without CNS	1/1/2013	12/31/2999
88005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; with brain	1/1/2013	12/31/2999
88007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; with brain and spinal cord	1/1/2013	12/31/2999
88012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; infant with brain	1/1/2013	12/31/2999
88014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	1/1/2013	12/31/2999
88016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross examination only; macerated stillborn	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; without CNS	1/1/2013	12/31/2999
88025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; with brain	1/1/2013	12/31/2999
88027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; with brain and spinal cord	1/1/2013	12/31/2999
88028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; infant with brain	1/1/2013	12/31/2999
88029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	1/1/2013	12/31/2999
88036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), limited, gross and/or microscopic; regional	1/1/2013	12/31/2999
88037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy), limited, gross and/or microscopic; single organ	1/1/2013	12/31/2999
88040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Necropsy (autopsy); forensic examination	1/1/2013	12/31/2999
88240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryopreservation, freezing and storage of cells, each cell line	7/15/2016	12/31/2999
88241	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Thawing and expansion of frozen cells, each aliquot	7/15/2016	12/31/2999
88245	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	1/1/2013	12/31/2999
88248	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
88249	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	1/1/2013	12/31/2999
88261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis; count 5 cells, 1 karyotype, with banding	1/1/2013	12/31/2999
88263	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	1/1/2013	12/31/2999
88264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Chromosome analysis; analyze 20-25 cells	1/1/2013	12/31/2999
88375	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	2/15/2015	12/31/2999
89250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Culture of oocyte(s)/embryo(s), less than 4 days;	1/15/2022	12/31/2999
89251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	1/15/2022	12/31/2999
89253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted embryo hatching, microtechniques (any method)	1/15/2022	12/31/2999
89254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oocyte identification from follicular fluid	11/1/2015	12/31/2999
89255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Preparation of embryo for transfer (any method)	11/1/2015	12/31/2999
89257	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sperm identification from aspiration (other than seminal fluid)	1/1/2013	12/31/2999
89258	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; embryo(s)	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
89259	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation; sperm	11/1/2015	12/31/2999
89260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	1/1/2013	12/31/2999
89261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	1/1/2024	12/31/2999
89264	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm identification from testis tissue, fresh or cryopreserved	11/1/2015	12/31/2999
89268	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Insemination of oocytes	11/1/2015	12/31/2999
89272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extended culture of oocyte(s)/embryo(s), 4-7 days	11/1/2015	12/31/2999
89280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	11/1/2015	12/31/2999
89281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	11/1/2015	12/31/2999
89290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	1/1/2013	12/31/2999
89291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	1/1/2013	12/31/2999
89329	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation; hamster penetration test	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
89330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	11/1/2015	12/31/2999
89331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	11/1/2015	12/31/2999
89335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, reproductive tissue, testicular	11/1/2015	12/31/2999
89337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreservation, mature oocyte(s)	11/1/2015	12/31/2999
89342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); embryo(s)	11/1/2015	12/31/2999
89343	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); sperm/semen	11/1/2015	12/31/2999
89344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); reproductive tissue, testicular/ovarian	11/1/2015	12/31/2999
89346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage (per year); oocyte(s)	11/1/2015	12/31/2999
89352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; embryo(s)	11/1/2015	12/31/2999
89353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; sperm/semen, each aliquot	11/1/2015	12/31/2999
89354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	11/1/2015	12/31/2999
89356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thawing of cryopreserved; oocytes, each aliquot	11/1/2015	12/31/2999
90287	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Botulinum antitoxin, equine, any route	4/1/2015	12/31/2999
90288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Botulism immune globulin, human, for intravenous use	4/1/2015	12/31/2999
90393	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vaccinia immune globulin, human, for intramuscular use	4/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90476	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adenovirus vaccine, type 4, live, for oral use	4/1/2015	12/31/2999
90477	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adenovirus vaccine, type 7, live, for oral use	4/1/2015	12/31/2999
90584	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use	7/1/2022	12/31/2999
90612	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, trivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 31.7 mcg/0.32 mL dosage, for intramuscular use	7/1/2025	12/31/2999
90613	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent, and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 40 mcg/0.4 mL dosage, for intramuscular use	7/1/2025	12/31/2999
90624	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meningococcal pentavalent vaccine, Men B-4C recombinant proteins and outer membrane vesicle and conjugated Men A, C, W, Y-diphtheria toxoid carrier, for intramuscular use	10/1/2024	12/31/2999
90637	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage, for intramuscular use	7/1/2024	12/31/2999
90638	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage, for intramuscular use	7/1/2024	12/31/2999
90664	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza virus vaccine, live (LAIV), pandemic formulation, for intranasal use	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90846	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Family psychotherapy (without the patient present), 50 minutes	1/1/2013	12/31/2999
90867	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	1/1/2013	12/31/2999
90868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	1/1/2013	12/31/2999
90869	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	1/1/2013	12/31/2999
90880	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hypnotherapy	5/1/2024	12/31/2999
90882	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	1/1/2013	12/31/2999
90885	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
90887	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	1/1/2013	12/31/2999
90889	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	1/1/2013	12/31/2999
91034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	1/1/2013	12/31/2999
91035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	1/1/2013	12/31/2999
91037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;	1/1/2013	12/31/2999
91038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
91065	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)	12/1/2020	12/31/2999
91110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	1/1/2013	12/31/2999
91111	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	12/1/2020	12/31/2999
91112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	2/15/2015	12/31/2999
91113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	1/1/2023	12/31/2999
91117	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	12/1/2020	12/31/2999
91132	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrogastrography, diagnostic, transcutaneous;	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
91133	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrogastrography, diagnostic, transcutaneous; with provocative testing	2/15/2015	12/31/2999
92065	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Orthoptic training; performed by a physician or other qualified health care professional	1/1/2026	12/31/2999
92066	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Orthoptic training; under supervision of a physician or other qualified health care professional	1/1/2023	12/31/2999
92132	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Scanning computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral	2/15/2015	12/31/2999
92145	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	12/1/2020	12/31/2999
92512	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nasal function studies (eg, rhinomanometry)	2/15/2015	12/31/2999
92517	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	5/15/2021	12/31/2999
92518	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92519	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	5/15/2021	12/31/2999
92548	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;	12/1/2020	12/31/2999
92549	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)	12/1/2020	12/31/2999
92596	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ear protector attenuation measurements	1/1/2013	12/31/2999
92601	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	1/1/2013	12/31/2999
92602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	1/1/2013	12/31/2999
92603	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	1/1/2013	12/31/2999
92604	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92605	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	1/1/2013	12/31/2999
92606	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	1/1/2013	12/31/2999
92607	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	1/1/2013	12/31/2999
92608	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
92609	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic services for the use of speech-generating device, including programming and modification	5/1/2015	12/31/2999
92618	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999
92622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
92623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999
92633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Auditory rehabilitation; postlingual hearing loss	1/1/2013	12/31/2999
92972	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999
92974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)	6/1/2015	12/31/2999
93025	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microvolt T-wave alternans for assessment of ventricular arrhythmias	1/1/2013	12/31/2999
93050	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	5/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); without programming	1/1/2026	12/31/2999
93146	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming, including optimization of tolerated therapeutic level setting	1/1/2026	12/31/2999
93150	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93151	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999
93152	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	5/15/2024	12/31/2999
93153	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interrogation without programming of implanted phrenic nerve stimulator system	5/15/2024	12/31/2999
93228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	1/1/2020	12/31/2999
93260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	1/1/2015	12/31/2999
93261	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93264	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	9/1/2020	12/31/2999
93282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	1/1/2013	12/31/2999
93283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	8/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93284	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	1/1/2013	12/31/2999
93285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	9/15/2016	12/31/2999
93287	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93289	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	1/1/2013	12/31/2999
93290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	9/15/2016	12/31/2999
93291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	1/1/2013	12/31/2999
93296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	1/1/2013	12/31/2999
93297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	9/15/2016	12/31/2999
93298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	9/15/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	1/1/2013	12/31/2999
93640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;	1/1/2013	12/31/2999
93641	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	1/1/2013	12/31/2999
93642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of single or dual chamber transvenous pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
93644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	1/1/2015	12/31/2999
93660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	1/1/2013	12/31/2999
93668	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Peripheral arterial disease (PAD) rehabilitation, per session	1/1/2013	12/31/2999
93702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	10/15/2025	12/31/2999
93740	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Temperature gradient studies	2/15/2015	12/31/2999
93750	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
94014	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	2/15/2015	12/31/2999
94015	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	2/15/2015	12/31/2999
94016	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional	2/15/2015	12/31/2999
94452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional;	1/1/2013	12/31/2999
94453	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration	1/1/2013	12/31/2999
94669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical chest wall oscillation to facilitate lung function, per session	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95027	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	1/1/2013	12/31/2999
95060	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ophthalmic mucous membrane tests	12/1/2020	12/31/2999
95065	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Direct nasal mucous membrane test	12/1/2020	12/31/2999
95249	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	1/1/2018	12/31/2999
95700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	1/1/2020	12/31/2999
95705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	1/1/2020	12/31/2999
95707	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	1/1/2020	12/31/2999
95708	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	1/1/2020	12/31/2999
95709	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	1/1/2020	12/31/2999
95710	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	1/1/2020	12/31/2999
95711	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	1/1/2020	12/31/2999
95712	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95713	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	1/1/2020	12/31/2999
95714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	1/1/2020	12/31/2999
95715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	1/1/2020	12/31/2999
95716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	1/1/2020	12/31/2999
95717	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95718	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	1/1/2020	12/31/2999
95719	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	1/1/2020	12/31/2999
95720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	1/1/2020	12/31/2999
95721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	1/1/2020	12/31/2999
95723	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	1/1/2020	12/31/2999
95724	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	1/1/2020	12/31/2999
95725	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	1/1/2020	12/31/2999
95782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	6/15/2021	12/31/2999
95783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	6/15/2021	12/31/2999
95803	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	10/1/2024	12/31/2999
95805	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	1/1/2013	12/31/2999
95919	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95921	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	1/1/2019	12/31/2999
95922	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	1/1/2019	12/31/2999
95923	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	1/1/2019	12/31/2999
95924	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	1/1/2019	12/31/2999
95925	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95926	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	1/1/2013	12/31/2999
95927	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	1/1/2013	12/31/2999
95930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	1/1/2013	12/31/2999
95938	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	9/15/2016	12/31/2999
95954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)	12/1/2014	12/31/2999
95957	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	8/1/2015	12/31/2999
95962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	8/1/2015	12/31/2999
95965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	1/1/2013	12/31/2999
95966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)	1/1/2013	12/31/2999
95967	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1/1/2019	12/31/2999
95977	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
95980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	1/1/2013	12/31/2999
95981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	1/1/2013	12/31/2999
95982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	1/1/2013	12/31/2999
95999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted neurological or neuromuscular diagnostic procedure	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics;	1/1/2013	12/31/2999
96001	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	1/1/2013	12/31/2999
96002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	1/1/2013	12/31/2999
96004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	1/1/2013	12/31/2999
96547	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999
96548	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
96570	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	1/1/2013	12/31/2999
96571	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)	1/1/2013	12/31/2999
96912	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photochemotherapy; psoralens and ultraviolet A (PUVA)	1/1/2013	12/31/2999
96913	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	1/1/2013	12/31/2999
96920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excimer laser treatment for psoriasis; total area less than 250 sq cm	6/1/2021	12/31/2999
96921	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm	6/1/2021	12/31/2999
96922	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Excimer laser treatment for psoriasis; over 500 sq cm	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education	1/1/2026	12/31/2999
97008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period	1/1/2026	12/31/2999
97009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure)	1/1/2026	12/31/2999
97533	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	9/1/2020	12/31/2999
97537	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	1/1/2020	12/31/2999
97545	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Work hardening/conditioning; initial 2 hours	1/1/2020	12/31/2999
97546	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	1/1/2013	12/31/2999
97606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	1/1/2013	12/31/2999
97607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
97608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	1/1/2015	12/31/2999
97610	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	2/15/2015	12/31/2999
99071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	5/15/2016	12/31/2999
99075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical testimony	5/15/2016	12/31/2999
99080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	5/15/2016	12/31/2999
99082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unusual travel (eg, transportation and escort of patient)	1/1/2021	12/31/2999
99174	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report	1/1/2016	12/31/2999
99177	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
99183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	1/1/2013	12/31/2999
99506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home visit for intramuscular injections	11/1/2016	12/31/2999
A0021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ambulance service, outside state per mile, transport (medicaid only)	1/1/2013	12/31/2999
A0080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	1/1/2013	12/31/2999
A0090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	1/1/2013	12/31/2999
A0100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation; taxi	1/1/2013	12/31/2999
A0110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and bus, intra or inter state carrier	1/1/2013	12/31/2999
A0120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	1/1/2013	12/31/2999
A0130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: wheel-chair van	1/1/2013	12/31/2999
A0140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation and air travel (private or commercial) intra or inter state	1/1/2013	12/31/2999
A0160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: per mile - case worker or social worker	1/1/2013	12/31/2999
A0170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation ancillary: parking fees, tolls, other	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging-recipient	1/1/2013	12/31/2999
A0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-recipient	1/1/2013	12/31/2999
A0200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: lodging escort	1/1/2013	12/31/2999
A0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-emergency transportation: ancillary: meals-escort	1/1/2013	12/31/2999
A0225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, neonatal transport, base rate, emergency transport, one way	8/1/2016	12/31/2999
A0380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bls mileage (per mile)	8/1/2016	12/31/2999
A0390	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Als mileage (per mile)	8/1/2016	12/31/2999
A0420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ambulance waiting time (als or bls), one half (1/2) hour increments	1/1/2013	12/31/2999
A0425	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ground mileage, per statute mile	8/1/2016	12/31/2999
A0426	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)	6/1/2015	12/31/2999
A0427	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, advanced life support, emergency transport, level 1 (als1-emergency)	6/1/2015	12/31/2999
A0428	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, basic life support, non-emergency transport, (bls)	7/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A0429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, basic life support, emergency transport (bls-emergency)	8/1/2016	12/31/2999
A0432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers	1/1/2013	12/31/2999
A0433	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Advanced life support, level 2 (als 2)	8/1/2016	12/31/2999
A0434	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Specialty care transport (sct)	8/1/2016	12/31/2999
A0888	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility)	9/1/2020	12/31/2999
A0998	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT	1/1/2013	12/31/2999
A0999	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Unlisted ambulance service	8/1/2016	12/31/2999
A0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted ambulance service	1/1/1950	12/31/2999
A2001	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix ac, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirragen advanced wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellistem, 1 mg	4/15/2022	12/31/2999
A2005	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Microlyte matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2006	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novosorb synpath dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2007	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2008	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Theragenesis, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2009	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Symphony, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999
A2010	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Apis, per square centimeter (add-on, list separately in addition to primary procedure)	4/15/2022	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2019	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3 marigen shield, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
A2020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ac5 advanced wound system (ac5)	9/1/2023	12/31/2999
A2021	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
A2022	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovaburn or innovamatrix xl, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2023	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Innovamatrix pd, 1 mg	10/1/2023	12/31/2999
A2024	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Resolve matrix or xenopatch, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2025	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d, per cubic centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999
A2026	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Restrata minimatrix, 5 mg	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2027	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Matriderm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
A2028	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Micromatrix flex, per mg	5/15/2025	12/31/2999
A2029	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirotract wound matrix sheet, per cubic centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
A2030	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miro3d fibers, per milligram	9/15/2025	12/31/2999
A2031	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mirodry wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
A2032	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad matrix, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
A2033	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Myriad morcells, 4 milligrams	9/15/2025	12/31/2999
A2034	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Foundation drs solo, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A2035	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex p or theracor p or allacor p, per milligram	9/15/2025	12/31/2999
A2036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cohealyx collagen dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
A2037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	G4derm plus, per milliliter	10/1/2025	12/31/2999
A2038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Marigen pacto, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
A2039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Innovamatrix fd, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
A4100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-sheet form skin substitute, fda cleared as a device, not otherwise specified (list in addition to primary procedure)	4/1/2022	12/31/2999
A4226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week	1/1/2020	12/31/2999
A4244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol or peroxide, per pint	1/1/2022	12/31/2999
A4245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol wipes, per box	1/1/2022	12/31/2999
A4246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Betadine or phisohex solution, per pint	1/1/2022	12/31/2999
A4247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Betadine or iodine swabs/wipes, per box	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sacral nerve stimulation test lead, each	1/1/2013	12/31/2999
A4335	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Incontinence supply; miscellaneous	10/24/2019	12/31/2999
A4337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incontinence supply, rectal insert, any type, each	1/1/2016	12/31/2999
A4341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each	11/15/2023	12/31/2999
A4342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each	11/15/2023	12/31/2999
A4421	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Ostomy supply; miscellaneous	1/1/1950	12/31/2999
A4438	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each	4/1/2024	12/31/2999
A4450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tape, non-waterproof, per 18 square inches	1/1/2022	12/31/2999
A4452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tape, waterproof, per 18 square inches	1/1/2022	12/31/2999
A4457	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enema tube, with or without adapter, any type, replacement only, each	1/1/2024	12/31/2999
A4458	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enema bag with tubing, reusable	8/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Exsufflation belt, includes all supplies and accessories	1/1/2024	12/31/2999
A4490	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings above knee length, each	1/1/2022	12/31/2999
A4495	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings thigh length, each	1/1/2022	12/31/2999
A4500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings below knee length, each	1/1/2022	12/31/2999
A4510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stockings full length, each	1/1/2022	12/31/2999
A4520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH	1/1/2017	12/31/2999
A4540	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	12/15/2025	12/31/2999
A4541	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monthly supplies for use of device coded at e0733	1/1/2024	12/31/2999
A4542	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
A4543	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	5/15/2025	12/31/2999
A4545	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4553	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-disposable underpads, all sizes	1/1/2017	12/31/2999
A4554	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Disposable underpads, all sizes	1/1/2017	12/31/2999
A4555	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	6/15/2017	12/31/2999
A4560	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neuromuscular electrical stimulator (nmes), disposable, replacement only	1/15/2024	12/31/2999
A4575	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Topical hyperbaric oxygen chamber, disposable	12/1/2020	12/31/2999
A4593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller	5/15/2025	12/31/2999
A4594	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each	5/15/2025	12/31/2999
A4595	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulator supplies, 2 lead, per month, (e. G. Tens, nmes)	1/1/2013	12/31/2999
A4596	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system supplies and accessories, per month	4/1/2023	12/31/2999
A4600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4606	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oxygen probe for use with oximeter device, replacement	10/15/2022	12/31/2999
A4630	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	REPLACEMENT BATTERIES, MEDICALLY NECESSARY, TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT	1/1/2013	12/31/2999
A4638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement battery for patient-owned ear pulse generator, each	9/1/2020	12/31/2999
A4639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Replacement pad for infrared heating pad system, each	10/1/2025	12/31/2999
A4641	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, DIAGNOSTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A4649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Surgical supply; miscellaneous	1/1/1950	12/31/2999
A4660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	1/1/2022	12/31/2999
A4663	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure cuff only	1/1/2022	12/31/2999
A4870	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Plumbing and/or electrical work for home hemodialysis equipment	1/1/2022	12/31/2999
A4913	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dialysis supplies, not otherwise specified	1/1/1950	12/31/2999
A4927	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gloves, non-sterile, per 100	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A4928	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical mask, per 20	1/1/2022	12/31/2999
A4930	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gloves, sterile, per pair	1/1/2022	12/31/2999
A4931	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oral thermometer, reusable, any type, each	1/1/2022	12/31/2999
A4932	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rectal thermometer, reusable, any type, each	1/1/2022	12/31/2999
A5507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	1/1/1950	12/31/2999
A6000	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card	2/15/2015	12/31/2999
A6261	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6262	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
A6512	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compression burn garment, not otherwise classified	10/24/2019	12/31/2999
A6519	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for nighttime use, each	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A6549	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Gradient compression garment, not otherwise specified, for daytime use, each	10/24/2019	12/31/2999
A6550	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES	1/1/2013	12/31/2999
A7020	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	1/1/2013	12/31/2999
A7025	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each	1/1/2013	12/31/2999
A7026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	1/1/2013	12/31/2999
A7049	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Expiratory positive airway pressure intranasal resistance valve	9/1/2023	12/31/2999
A8000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/2022	12/31/2999
A8001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/2022	12/31/2999
A8002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A8003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/2022	12/31/2999
A8004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	1/1/2022	12/31/2999
A9150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-prescription drugs	1/1/2012	12/31/2999
A9152	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9153	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
A9270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-covered item or service	1/1/2012	12/31/2999
A9272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wound suction, disposable, includes dressing, all accessories and components, any type, each	1/1/2013	12/31/2999
A9273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	1/1/2021	12/31/2999
A9279	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED	1/1/2007	12/31/2999
A9280	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alert or alarm device, not otherwise classified	1/1/1950	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REACHING/GRABBING DEVICE, ANY TYPE, ANY LENGTH, EACH	1/1/2022	12/31/2999
A9282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	WIG, ANY TYPE, EACH	4/1/2015	12/31/2999
A9286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hygienic item or device, disposable or non-disposable, any type, each	1/1/2017	12/31/2999
A9291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment	2/1/2024	12/31/2999
A9300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Exercise equipment	1/1/2013	12/31/2999
A9515	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Choline c-11, diagnostic, per study dose up to 20 millicuries	11/1/2018	12/31/2999
A9526	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	NITROGEN N-13 AMMONIA, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES	3/1/2021	12/31/2999
A9552	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	FLUORODEOXYGLUCOSE F-18 FDG, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES	3/1/2021	12/31/2999
A9555	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	RUBIDIUM RB-82, DIAGNOSTIC, PER STUDY DOSE, UP TO 60 MILLICURIES	3/1/2021	12/31/2999
A9573	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, gadopiclenol, 1 ml	10/1/2023	12/31/2999
A9579	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, NOT OTHERWISE SPECIFIED (NOS), per ml	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9580	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES	6/1/2015	12/31/2999
A9582	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	IODINE I-123 IOBENGUANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES	6/1/2015	12/31/2999
A9586	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	8/1/2019	12/31/2999
A9587	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	1/1/2017	12/31/2999
A9588	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluciclovine f-18, diagnostic, 1 millicurie	1/1/2017	12/31/2999
A9591	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluoroestradiol f 18, diagnostic, 1 millicurie	1/1/2021	12/31/2999
A9592	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Copper cu-64, dotatate, diagnostic, 1 millicurie	4/1/2021	12/31/2999
A9593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 psma-11, diagnostic, (ucsf), 1 millicurie	7/1/2021	12/31/2999
A9594	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 psma-11, diagnostic, (ucla), 1 millicurie	7/1/2021	12/31/2999
A9595	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Piflufolastat f-18, diagnostic, 1 millicurie	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie	7/1/2022	12/31/2999
A9597	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9598	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9598	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	1/1/2017	12/31/2999
A9601	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flortaucipir f 18 injection, diagnostic, 1 millicurie	7/1/2022	12/31/2999
A9602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fluorodopa f-18, diagnostic, per millicurie	10/1/2022	12/31/2999
A9608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flotufolastat f 18, diagnostic, 1 millicurie	1/1/2024	12/31/2999
A9609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fludeoxyglucose f18 up to 15 millicuries	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
A9611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flurpiridaz f 18, diagnostic, 1 millicurie	4/1/2025	12/31/2999
A9616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide (gozellix), diagnostic, 1 millicurie	10/1/2025	12/31/2999
A9698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	NON-RADIOACTIVE CONTRAST IMAGING MATERIAL, NOT OTHERWISE CLASSIFIED, PER STUDY	1/1/2006	12/31/2999
A9699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	RADIOPHARMACEUTICAL, THERAPEUTIC, NOT OTHERWISE CLASSIFIED	1/1/1950	12/31/2999
A9800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie	10/1/2022	12/31/2999
A9900	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply, accessory, and/or service component of another hcpcs code	4/16/2015	12/31/2999
A9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous dme supply or accessory, not otherwise specified	1/1/1950	12/31/2999
B4100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Food thickener, administered orally, per ounce	1/1/2022	12/31/2999
B4102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	2/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4103	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT	2/1/2020	12/31/2999
B4104	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER)	2/1/2020	12/31/2999
B4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	2/1/2020	12/31/2999
B4149	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2013	12/31/2999
B4150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999
B4152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999
B4154	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999
B4155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e. G. Glucose polymers), proteins/amino acids (e. G. Glutamine, arginine), fat (e. G. Medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit	1/1/2013	12/31/2999
B4158	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2013	12/31/2999
B4160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2013	12/31/2999
B4161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	1/1/2013	12/31/2999
B4164	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix	1/1/2013	12/31/2999
B4168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 3. 5%, (500 ml = 1 unit) - homemix	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4172	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 5. 5% through 7%, (500 ml = 1 unit) - homemix	1/1/2013	12/31/2999
B4176	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; amino acid, 7% through 8. 5%, (500 ml = 1 unit) - homemix	1/1/2013	12/31/2999
B4178	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution: amino acid, greater than 8. 5% (500 ml = 1 unit) - homemix	1/1/2013	12/31/2999
B4180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml=1 unit) - homemix	1/1/2013	12/31/2999
B4185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	1/1/2013	12/31/2999
B4187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Omegaven, 10 grams lipids	1/1/2020	12/31/2999
B4189	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix	1/1/2013	12/31/2999
B4193	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B4197	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix	1/1/2013	12/31/2999
B4199	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix	1/1/2013	12/31/2999
B4216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) homemix per day	1/1/2013	12/31/2999
B4220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition supply kit; premix, per day	1/1/2013	12/31/2999
B4222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition supply kit; home mix, per day	1/1/2013	12/31/2999
B4224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition administration kit, per day	1/1/2013	12/31/2999
B5000	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
B5100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, hepatamine-premix	1/1/2013	12/31/2999
B5200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix	1/1/2013	12/31/2999
B9002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Enteral nutrition infusion pump, any type	1/1/2013	12/31/2999
B9004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition infusion pump, portable	1/1/2013	12/31/2999
B9006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Parenteral nutrition infusion pump, stationary	1/1/2013	12/31/2999
B9998	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for enteral supplies	4/16/2015	12/31/2999
B9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc for parenteral supplies	1/1/1950	12/31/2999
C1052	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hemostatic agent, gastrointestinal, topical	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1062	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2999
C1600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	1/1/2024	12/31/2999
C1607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system	1/1/2026	12/31/2999
C1717	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, high dose rate iridium-192, per source	1/1/2013	12/31/2999
C1721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardioverter-defibrillator, dual chamber (implantable)	11/1/2019	12/31/2999
C1722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardioverter-defibrillator, single chamber (implantable)	11/1/2019	12/31/2999
C1734	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	9/1/2020	12/31/2999
C1735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	10/15/2025	12/31/2999
C1736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	10/15/2025	12/31/2999
C1737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1740	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leadless electrode, transmitter, battery (all implantable), for sequential left ventricular pacing	10/1/2025	12/31/2999
C1764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Event recorder, cardiac (implantable)	4/15/2018	12/31/2999
C1767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), non-rechargeable	1/1/2019	12/31/2999
C1776	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Joint device (implantable)	6/1/2017	12/31/2999
C1778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, neurostimulator (implantable)	8/1/2019	12/31/2999
C1783	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ocular implant, aqueous drainage assist device	3/15/2015	12/31/2999
C1787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient programmer, neurostimulator	8/1/2019	12/31/2999
C1816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receiver and/or transmitter, neurostimulator (implantable)	8/1/2019	12/31/2999
C1817	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Septal defect implant system, intracardiac	1/1/2013	12/31/2999
C1818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integrated keratoprosthesis	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), with rechargeable battery and charging system	8/1/2019	12/31/2999
C1821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)	9/1/2020	12/31/2999
C1823	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	4/15/2022	12/31/2999
C1824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2999
C1825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2999
C1826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	7/1/2023	12/31/2999
C1827	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	9/1/2023	12/31/2999
C1831	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interbody cage, anterior, lateral or posterior, personalized (implantable)	10/1/2021	12/31/2999
C1832	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autograft suspension, including cell processing and application, and all system components	5/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C1833	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor, cardiac, including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2999
C1840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lens, intraocular (telescopic)	9/27/2013	12/31/2999
C1882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cardioverter-defibrillator, other than single or dual chamber (implantable)	11/1/2019	12/31/2999
C1883	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adapter/extension, pacing lead or neurostimulator lead (implantable)	8/1/2019	12/31/2999
C1889	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Implantable/insertable device, not otherwise classified	1/1/2017	12/31/2999
C1895	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	11/1/2019	12/31/2999
C1896	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	11/1/2019	12/31/2999
C1897	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, neurostimulator test kit (implantable)	5/1/2021	12/31/2999
C1899	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	11/1/2019	12/31/2999
C1982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter, pressure-generating, (e.g., one-way valve, intermittently occlusive)	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C2614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Probe, percutaneous lumbar discectomy	4/1/2020	12/31/2999
C2616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, yttrium-90, per source	1/1/2013	12/31/2999
C2623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Catheter, transluminal angioplasty, drug-coated, non-laser	12/15/2016	12/31/2999
C2624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	9/1/2020	12/31/2999
C2634	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, high activity, iodine-125, greater than 1.01 mci (nist), per source	1/1/2013	12/31/2999
C2635	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, high activity, palladium-103, greater than 2.2 mci (nist), per source	1/1/2013	12/31/2999
C2636	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy linear source, non-stranded, palladium-103, per 1 mm	1/1/2013	12/31/2999
C2637	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, non-stranded, ytterbium-169, per source	1/1/2013	12/31/2999
C2638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, STRANDED, IODINE-125, PER SOURCE	1/1/2013	12/31/2999
C2639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, NON-STRANDED, IODINE-125, PER SOURCE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C2640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, STRANDED, PALLADIUM-103, PER SOURCE	1/1/2013	12/31/2999
C2641	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, NON-STRANDED, PALLADIUM-103, PER SOURCE	1/1/2013	12/31/2999
C2642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, STRANDED, CESIUM-131, PER SOURCE	1/1/2013	12/31/2999
C2643	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, NON-STRANDED, CESIUM-131, PER SOURCE	1/1/2013	12/31/2999
C2644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy source, cesium-131 chloride solution, per millicurie	7/1/2014	12/31/2999
C2645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brachytherapy planar source, palladium-103, per square millimeter	1/1/2016	12/31/2999
C2698	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	1/1/2013	12/31/2999
C2698	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999
C2699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	BRACHYTHERAPY SOURCE, NON-STRANDED, NOT OTHERWISE SPECIFIED, PER SOURCE	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C7504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	1/1/2024	12/31/2999
C7505	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	1/1/2024	12/31/2999
C7507	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	6/1/2023	12/31/2999
C7508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	6/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C7531	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999
C7534	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with atherectomy, includes angioplasty within the same vessel, when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999
C7535	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal stent placement(s), includes angioplasty within the same vessel, when performed, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C7563	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, initial artery and all additional arteries	1/1/2025	12/31/2999
C7564	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance with intravascular ultrasound (noncoronary vessel(s)) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	1/1/2025	12/31/2999
C7571	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with percutaneous transluminal coronary lithotripsy	1/1/2026	12/31/2999
C8001	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C8002	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	6/15/2025	12/31/2999
C8003	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)	12/15/2025	12/31/2999
C9047	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, caplacizumab-yhdp, 1 mg	7/1/2019	12/31/2999
C9067	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gallium ga-68, dotatoc, diagnostic, 0.01 mci	10/1/2020	12/31/2999
C9176	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tc-99m from domestically produced non-heu mo-99, [minimum 50 percent], full cost recovery add-on, per study dose	1/1/2026	12/31/2999
C9307	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, linvoseltamab-gcpt, 1 mg	1/1/2026	12/31/2999
C9308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, carboplatin (avyxa), 1 mg	1/1/2026	12/31/2999
C9354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	12/1/2020	12/31/2999
C9358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	12/1/2020	12/31/2999
C9359	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	4/1/2021	12/31/2999
C9360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	12/1/2020	12/31/2999
C9362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	4/1/2021	12/31/2999
C9363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	5/15/2021	12/31/2999
C9364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Porcine implant, Permacol, per square centimeter	12/1/2020	12/31/2999
C9399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unclassified drugs or biologicals	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Placement and removal (if performed) of applicator into breast for radiation therapy	1/1/2013	12/31/2999
C9727	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of implants into the soft palate; minimum of three implants	1/1/2013	12/31/2999
C9734	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	7/1/2015	12/31/2999
C9739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	12/1/2015	12/31/2999
C9740	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	12/1/2015	12/31/2999
C9757	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	8/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-randomized, non-blinded procedure for nyha class ii, iii, iv heart failure; transcatheter implantation of interatrial shunt, including right and left heart catheterization, transeptal puncture, trans-esophageal echocardiography (tee)/intracardiac echocardiography (ice), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study	7/1/2020	12/31/2999
C9764	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	5/15/2021	12/31/2999
C9765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed	5/15/2021	12/31/2999
C9766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	5/15/2021	12/31/2999
C9767	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	5/15/2021	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Colpopexy, vaginal; minimally invasive extra-peritoneal approach (sacrospinous)	7/1/2021	12/31/2999
C9782	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study	4/1/2022	12/31/2999
C9783	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control, including vascular access and closure, right heart catherization, venous and coronary sinus angiography, imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (ide) study	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9792	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded or nonblinded procedure for symptomatic new york heart association (nyha) class ii, iii, iva heart failure; transcatheter implantation of left atrial to coronary sinus shunt using jugular vein access, including all imaging necessary to intra procedurally map the coronary sinus for optimal shunt placement (e.g., tee or ice ultrasound, fluoroscopy), performed under general anesthesia in an approved investigational device exemption (ide) study)	10/1/2023	12/31/2999
C9807	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	6/15/2025	12/31/2999
C9808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
C9809	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	3/1/2025	12/31/2999
C9810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Water circulating motorized cold therapy device (e.g., iceman) including all system components (e.g. pads, console, disposable parts), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	1/1/2026	12/31/2999
C9817	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic cryo-pneumatic compression, pain management system (e.g. game ready grpro 2.1 system), including control unit, anatomically correct wrap(s), and other system component(s), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	1/1/2026	12/31/2999
C9898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Radiolabeled product provided during a hospital inpatient stay	1/1/2012	12/31/2999
C9899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	IMPLANTED PROSTHETIC DEVICE, PAYABLE ONLY FOR INPATIENTS WHO DO NOT HAVE INPATIENT COVERAGE	1/1/2012	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	1/1/2013	12/31/2999
D0140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	limited oral evaluation - problem focused	1/1/2013	12/31/2999
D0145	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	1/1/2013	12/31/2999
D0150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	comprehensive oral evaluation - new or established patient	1/1/2013	12/31/2999
D0160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	detailed and extensive oral evaluation - problem focused, by report	1/1/2013	12/31/2999
D0170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-evaluation - limited, problem focused (established patient; not post-operative visit)	1/1/2013	12/31/2999
D0171	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-evaluation ? post-operative office visit	1/1/2015	12/31/2999
D0180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	comprehensive periodontal evaluation - new or established patient	1/1/2013	12/31/2999
D0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	screening of a patient	1/1/2013	12/31/2999
D0191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	assessment of a patient	1/1/2013	12/31/2999
D0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral - comprehensive series of radiographic images	1/1/2013	12/31/2999
D0220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral - periapical first radiographic image	1/1/2013	12/31/2999
D0230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral - periapical each additional radiographic image	1/1/2013	12/31/2999
D0240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral - occlusal radiographic image	1/1/2013	12/31/2999
D0250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	extraoral - first radiographic image	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bitewing - single radiographic image	1/1/2013	12/31/2999
D0272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bitewings - two radiographic images	1/1/2013	12/31/2999
D0273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bitewings - three radiographic images	1/1/2013	12/31/2999
D0274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bitewings - four radiographic images	1/1/2013	12/31/2999
D0277	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	vertical bitewings - 7 to 8 radiographic images	1/1/2013	12/31/2999
D0310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	sialography	1/1/2013	12/31/2999
D0320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	temporomandibular joint arthrogram, including injection	1/1/2013	12/31/2999
D0321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	other temporomandibular joint radiographic images, by report	1/1/2013	12/31/2999
D0322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	tomographic survey	1/1/2013	12/31/2999
D0330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	panoramic radiographic image	1/1/2013	12/31/2999
D0340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cephalometric radiographic image	1/1/2013	12/31/2999
D0350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2D oral/facial photographic image obtained intra-orally or extra-orally	1/1/2013	12/31/2999
D0364	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT capture and interpretation with limited field of view ? less than one whole jaw	1/1/2013	12/31/2999
D0365	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT capture and interpretation with field of view of one full dental arch ? mandible	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0366	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT capture and interpretation with field of view of one full dental arch ? maxilla, with or without cranium	1/1/2013	12/31/2999
D0367	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	1/1/2013	12/31/2999
D0368	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT capture and interpretation for TMJ series including two or more exposures	1/1/2013	12/31/2999
D0369	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillofacial MRI capture and interpretation	1/1/2013	12/31/2999
D0370	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillofacial ultrasound capture and interpretation	1/1/2013	12/31/2999
D0372	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? comprehensive series of radiographic images	1/1/2023	12/31/2999
D0373	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? bitewing radiographic image	1/1/2023	12/31/2999
D0374	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? periapical radiographic image	1/1/2023	12/31/2999
D0380	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT image capture with limited field of view ? less than one whole jaw	1/1/2013	12/31/2999
D0381	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT image capture with field of view of one full dental arch ? mandible	1/1/2013	12/31/2999
D0382	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT image capture with field of view of one full dental arch ? maxilla, with or without cranium	1/1/2013	12/31/2999
D0383	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT image capture with field of view of both jaws, with or without cranium	1/1/2013	12/31/2999
D0384	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cone beam CT image capture for TMJ series including two or more exposures	1/1/2013	12/31/2999
D0385	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillofacial MRI image capture	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0386	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillofacial ultrasound image capture	1/1/2013	12/31/2999
D0387	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? comprehensive series of radiographic images - image capture only	1/1/2023	12/31/2999
D0388	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? bitewing radiographic image - image capture only	1/1/2023	12/31/2999
D0389	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral tomosynthesis ? periapical radiographic image - image capture only	1/1/2023	12/31/2999
D0393	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	virtual treatment simulation using 3D image volume or surface scan	1/1/2014	12/31/2999
D0394	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	digital subtraction of two or more images or image volumes of the same modality	1/1/2014	12/31/2999
D0395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fusion of two or more 3D image volumes of one or more modalities	1/1/2014	12/31/2999
D0396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D printing of a 3D dental surface scan	1/1/2024	12/31/2999
D0415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	collection of microorganisms for culture and sensitivity	1/1/2013	12/31/2999
D0416	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	VIRAL CULTURE	1/1/2013	12/31/2999
D0417	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Collection and preparation of saliva sample for laboratory analysis	1/1/2013	12/31/2999
D0418	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Analysis of saliva sample - laboratory	1/1/2013	12/31/2999
D0419	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	assessment of salivary flow by measurement	1/1/2020	12/31/2999
D0422	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	collection and preparation of genetic sample material for laboratory analysis and report	1/1/2016	12/31/2999
D0423	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	genetic test for susceptibility to diseases ? specimen analysis	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0425	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	caries susceptibility tests	1/1/2013	12/31/2999
D0426	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	collection, preparation, and analysis of saliva sample - point-of-care	1/1/2026	12/31/2999
D0431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	1/1/2013	12/31/2999
D0460	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulp vitality tests	1/1/2013	12/31/2999
D0461	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	testing for cracked tooth	1/1/2026	12/31/2999
D0470	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DIAGNOSTIC CASTS	1/1/2013	12/31/2999
D0472	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	accession of tissue, gross examination, preparation and transmission of written report	1/1/2013	12/31/2999
D0473	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	accession of tissue, gross and microscopic examination, preparation and transmission of written report	1/1/2013	12/31/2999
D0474	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	1/1/2013	12/31/2999
D0480	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	1/1/2017	12/31/2999
D0601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	caries risk assessment and documentation, with a finding of low risk	1/1/2014	12/31/2999
D0602	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	caries risk assessment and documentation, with a finding of moderate risk	1/1/2014	12/31/2999
D0603	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	caries risk assessment and documentation, with a finding of high risk	1/1/2014	12/31/2999
D0701	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	panoramic radiographic image ? image capture only	1/1/2021	12/31/2999
D0702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2-D cephalometric radiographic image ? image capture only	1/1/2021	12/31/2999
D0703	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	2D oral/facial photographic image obtained intra-orally or extra-orally ? image capture only	1/1/2021	12/31/2999
D0705	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	extra-oral posterior dental radiographic image ? image capture only	1/1/2021	12/31/2999
D0706	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral ? occlusal radiographic image ? image capture only	1/1/2021	12/31/2999
D0707	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral ? periapical radiographic image ? image capture only	1/1/2021	12/31/2999
D0708	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral ? bitewing radiographic image ? image capture only	1/1/2021	12/31/2999
D0709	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraoral - comprehensive series of radiographic images - image capture only	1/1/2021	12/31/2999
D0801	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D intraoral surface scan - direct	1/1/2023	12/31/2999
D0802	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D dental surface scan ? indirect	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D0803	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D facial surface scan ? direct	1/1/2023	12/31/2999
D0804	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	3D facial surface scan ? indirect	1/1/2023	12/31/2999
D0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified diagnostic procedure, by report	10/24/2019	12/31/2999
D1110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prophylaxis - adult	1/1/2013	12/31/2999
D1120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prophylaxis - child	1/1/2013	12/31/2999
D1206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	topical application of fluoride varnish	1/1/2013	12/31/2999
D1208	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	topical application of fluoride ? excluding varnish	1/1/2013	12/31/2999
D1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling	1/1/2024	12/31/2999
D1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	nutritional counseling for control of dental disease	1/1/2013	12/31/2999
D1320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	tobacco counseling for the control and prevention of oral disease	1/1/2013	12/31/2999
D1330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	oral hygiene instructions	1/1/2013	12/31/2999
D1351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	sealant - per tooth	1/1/2013	12/31/2999
D1353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	sealant repair ? per tooth	1/1/2015	12/31/2999
D1354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	application of caries arresting medicament ? per tooth	1/1/2021	12/31/2999
D1355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	caries preventive medicament application ? per tooth	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D1510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	space maintainer ? fixed unilateral ? per quadrant	1/1/2013	12/31/2999
D1520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	space maintainer ? removable ? unilateral ? per quadrant	1/1/2013	12/31/2999
D1526	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	space maintainer ? removable ? bilateral, maxillary	1/1/2019	12/31/2999
D1527	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	space maintainer ? removable ? bilateral, mandibular	1/1/2019	12/31/2999
D1551	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond bilateral space maintainer ? maxillary	1/1/2020	12/31/2999
D1552	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond bilateral space maintainer ? mandibular	1/1/2020	12/31/2999
D1553	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond unilateral space maintainer ? per quadrant	1/1/2020	12/31/2999
D1556	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of fixed unilateral space maintainer ? per quadrant	1/1/2020	12/31/2999
D1557	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of fixed bilateral space maintainer ? maxillary	1/1/2020	12/31/2999
D1558	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of fixed bilateral space maintainer ? mandibular	1/1/2020	12/31/2999
D1575	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	distal shoe space maintainer ? fixed ? unilateral ? per quadrant	1/1/2017	12/31/2999
D1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified preventive procedure, by report	10/24/2019	12/31/2999
D1999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	unspecified preventive procedure, by report	1/1/2014	12/31/2999
D2140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	amalgam - one surface, primary or permanent	1/1/2013	12/31/2999
D2150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	amalgam - two surfaces, primary or permanent	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	amalgam - three surfaces, primary or permanent	1/1/2013	12/31/2999
D2161	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	amalgam - four or more surfaces, primary or permanent	1/1/2013	12/31/2999
D2330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - one surface, anterior	1/1/2013	12/31/2999
D2331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - two surfaces, anterior	1/1/2013	12/31/2999
D2332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - three surfaces, anterior	1/1/2013	12/31/2999
D2335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - four or more surfaces (anterior)	1/1/2013	12/31/2999
D2390	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite crown, anterior	1/1/2013	12/31/2999
D2391	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - one surface, posterior	1/1/2013	12/31/2999
D2392	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - two surfaces, posterior	1/1/2013	12/31/2999
D2393	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - three surfaces, posterior	1/1/2013	12/31/2999
D2394	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin-based composite - four or more surfaces, posterior	1/1/2013	12/31/2999
D2410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gold foil - one surface	1/1/2013	12/31/2999
D2420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gold foil - two surfaces	1/1/2013	12/31/2999
D2430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gold foil - three surfaces	1/1/2013	12/31/2999
D2510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - metallic - one surface	1/1/2013	12/31/2999
D2520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - metallic - two surfaces	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - metallic - three or more surfaces	1/1/2013	12/31/2999
D2542	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - metallic-two surfaces	1/1/2013	12/31/2999
D2543	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - metallic-three surfaces	1/1/2013	12/31/2999
D2544	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - metallic-four or more surfaces	1/1/2013	12/31/2999
D2610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - porcelain/ceramic - one surface	1/1/2013	12/31/2999
D2620	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - porcelain/ceramic - two surfaces	1/1/2013	12/31/2999
D2630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - porcelain/ceramic - three or more surfaces	1/1/2013	12/31/2999
D2642	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - porcelain/ceramic - two surfaces	1/1/2013	12/31/2999
D2643	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - porcelain/ceramic - three surfaces	1/1/2013	12/31/2999
D2644	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - porcelain/ceramic - four or more surfaces	1/1/2013	12/31/2999
D2650	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - resin-based composite - one surface	1/1/2013	12/31/2999
D2651	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - resin-based composite - two surfaces	1/1/2013	12/31/2999
D2652	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - resin-based composite - three or more surfaces	1/1/2013	12/31/2999
D2662	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - resin-based composite - two surfaces	1/1/2013	12/31/2999
D2663	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - resin-based composite - three surfaces	1/1/2013	12/31/2999
D2664	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - resin-based composite - four or more surfaces	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2710	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin-based composite (indirect)	1/1/2013	12/31/2999
D2712	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - ¾ resin-based composite (indirect)	1/1/2013	12/31/2999
D2720	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with high noble metal	1/1/2013	12/31/2999
D2721	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with predominantly base metal	1/1/2013	12/31/2999
D2722	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with noble metal	1/1/2013	12/31/2999
D2740	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Crown - porcelain/ceramic	1/1/2013	12/31/2999
D2750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to high noble metal	1/1/2013	12/31/2999
D2751	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to predominantly base metal	1/1/2013	12/31/2999
D2752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to noble metal	1/1/2013	12/31/2999
D2753	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D2780	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast high noble metal	1/1/2013	12/31/2999
D2781	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast predominantly base metal	1/1/2013	12/31/2999
D2782	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast noble metal	1/1/2013	12/31/2999
D2783	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 porcelain/ceramic	1/1/2013	12/31/2999
D2790	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast high noble metal	1/1/2013	12/31/2999
D2791	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast predominantly base metal	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2792	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast noble metal	1/1/2013	12/31/2999
D2794	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown ? titanium and titanium alloys	1/1/2013	12/31/2999
D2799	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim crown ? further treatment or completion of diagnosis necessary prior to final impression	1/1/2013	12/31/2999
D2910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1/1/2013	12/31/2999
D2915	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond indirectly fabricated or prefabricated post and core	1/1/2013	12/31/2999
D2920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond crown	1/1/2013	12/31/2999
D2921	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reattachment of tooth fragment, incisal edge or cusp	1/1/2014	12/31/2999
D2928	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated porcelain/ceramic crown ? permanent tooth	1/1/2021	12/31/2999
D2929	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated porcelain/ceramic crown ? primary tooth	1/1/2013	12/31/2999
D2930	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated stainless steel crown - primary tooth	1/1/2013	12/31/2999
D2931	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated stainless steel crown - permanent tooth	1/1/2013	12/31/2999
D2932	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PREFABRICATED RESIN CROWN	1/1/2013	12/31/2999
D2933	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated stainless steel crown with resin window	1/1/2013	12/31/2999
D2934	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	1/1/2013	12/31/2999
D2940	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Placement of interim direct restoration	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2949	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	restorative foundation for an indirect restoration	1/1/2014	12/31/2999
D2950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	core buildup, including any pins when required	1/1/2013	12/31/2999
D2951	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pin retention - per tooth, in addition to restoration	1/1/2013	12/31/2999
D2952	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	post and core in addition to crown, indirectly fabricated	1/1/2013	12/31/2999
D2953	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	1/1/2013	12/31/2999
D2954	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated post and core in addition to crown	1/1/2013	12/31/2999
D2955	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	post removal	1/1/2013	12/31/2999
D2957	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	each additional prefabricated post - same tooth	1/1/2013	12/31/2999
D2960	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	labial veneer (resin laminate) - chairside	1/1/2013	12/31/2999
D2961	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	labial veneer (resin laminate) - laboratory	1/1/2013	12/31/2999
D2962	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	labial veneer (porcelain laminate) - laboratory	1/1/2013	12/31/2999
D2975	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	coping	1/1/2013	12/31/2999
D2980	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown repair necessitated by restorative material failure	1/1/2013	12/31/2999
D2989	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	excavation of a tooth resulting in the determination of non-restorability	1/1/2024	12/31/2999
D2991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	application of hydroxyapatite regeneration medicament - per tooth	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified restorative procedure, by report	10/24/2019	12/31/2999
D3110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulp cap - direct (excluding final restoration)	1/1/2013	12/31/2999
D3120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulp cap - indirect (excluding final restoration)	1/1/2013	12/31/2999
D3220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis	1/1/2013	12/31/2999
D3221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal debridement, primary and permanent teeth	1/1/2013	12/31/2999
D3222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT	1/1/2013	12/31/2999
D3230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1/1/2013	12/31/2999
D3240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1/1/2013	12/31/2999
D3310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	endodontic therapy, anterior tooth (excluding final restoration)	1/1/2013	12/31/2999
D3320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Endodontic therapy, premolar tooth (excluding final restorations)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D3330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Endodontic therapy, molar tooth (excluding final restorations)	1/1/2013	12/31/2999
D3331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	treatment of root canal obstruction; non-surgical access	1/1/2013	12/31/2999
D3332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	1/1/2013	12/31/2999
D3333	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	internal root repair of perforation defects	1/1/2013	12/31/2999
D3346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retreatment of previous root canal therapy - anterior	1/1/2013	12/31/2999
D3347	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Retreatment of previous root canal therapy ? premolar	1/1/2013	12/31/2999
D3348	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retreatment of previous root canal therapy - molar	1/1/2013	12/31/2999
D3351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apexification/recalcification ? initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	1/1/2013	12/31/2999
D3352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	1/1/2013	12/31/2999
D3353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	1/1/2013	12/31/2999
D3355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal regeneration - initial visit	1/1/2014	12/31/2999
D3356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal regeneration - interim medication replacement	1/1/2014	12/31/2999
D3357	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pulpal regeneration - completion of treatment	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D3410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apicoectomy - anterior	1/1/2013	12/31/2999
D3421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Apicoectomy ? premolar (first root)	1/1/2013	12/31/2999
D3425	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apicoectomy - molar (first root)	1/1/2013	12/31/2999
D3426	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	apicoectomy (each additional root)	1/1/2013	12/31/2999
D3428	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bone graft in conjunction with periradicular surgery ? per tooth, single site	1/1/2014	12/31/2999
D3429	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bone graft in conjunction with periradicular surgery ? each additional contiguous tooth in the same surgical site	1/1/2014	12/31/2999
D3430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retrograde filling - per root	1/1/2013	12/31/2999
D3431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	1/1/2014	12/31/2999
D3432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	1/1/2014	12/31/2999
D3450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	root amputation - per root	1/1/2013	12/31/2999
D3460	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	endodontic endosseous implant	1/1/2013	12/31/2999
D3470	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intentional reimplantation (including necessary splinting)	1/1/2013	12/31/2999
D3471	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical repair of root resorption ? anterior	1/1/2021	12/31/2999
D3472	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical repair of root resorption ? premolar	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D3473	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical repair of root resorption ? molar	1/1/2021	12/31/2999
D3501	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical exposure of root surface without apicoectomy or repair of root resorption ? anterior	1/1/2021	12/31/2999
D3502	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical exposure of root surface without apicoectomy or repair of root resorption ? premolar	1/1/2021	12/31/2999
D3503	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical exposure of root surface without apicoectomy or repair of root resorption ? molar	1/1/2021	12/31/2999
D3910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical procedure for isolation of tooth with rubber dam	1/1/2013	12/31/2999
D3911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	intraorifice barrier	1/1/2022	12/31/2999
D3920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	hemisection (including any root removal), not including root canal therapy	1/1/2013	12/31/2999
D3921	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	decoronation or submergence of an erupted tooth	1/1/2022	12/31/2999
D3950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	canal preparation and fitting of preformed dowel or post	1/1/2013	12/31/2999
D3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified endodontic procedure, by report	10/24/2019	12/31/2999
D4210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999
D4211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D4212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	1/1/2013	12/31/2999
D4230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	anatomical crown exposure ? four or more contiguous teeth or tooth bounded tooth spaces per quadrant	1/1/2013	12/31/2999
D4231	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	anatomical crown exposure ? one to three teeth or tooth bounded tooth spaces per quadrant	1/1/2013	12/31/2999
D4240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999
D4241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999
D4245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	APICALLY POSITIONED FLAP	1/1/2013	12/31/2999
D4249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	clinical crown lengthening ? hard tissue	1/1/2013	12/31/2999
D4260	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	osseous surgery (including elevation of a full thickness flap and closure) ? four or more contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999
D4261	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	osseous surgery (including elevation of a full thickness flap and closure) ? one to three contiguous teeth or tooth bounded spaces per quadrant	1/1/2013	12/31/2999
D4263	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bone replacement graft - retained natural tooth - first site in quadrant	1/1/2013	12/31/2999
D4264	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bone replacement graft - retained natural tooth - each additional site in quadrant	1/1/2013	12/31/2999
D4265	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	biologic materials to aid in soft and osseous tissue regeneration, per site	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D4266	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	guided tissue regeneration, natural teeth - resorbable barrier, per site	1/1/2013	12/31/2999
D4267	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	guided tissue regeneration, natural teeth - non-resorbable barrier, per site	1/1/2013	12/31/2999
D4268	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical revision procedure, per tooth	1/1/2013	12/31/2999
D4270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pedicle soft tissue graft procedure	1/1/2013	12/31/2999
D4273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	subepithelial connective tissue graft procedures, per tooth	1/1/2013	12/31/2999
D4274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	1/1/2013	12/31/2999
D4275	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SOFT TISSUE ALLOGRAFT	1/1/2013	12/31/2999
D4276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	combined connective tissue and pedicle graft, per tooth	1/1/2013	12/31/2999
D4277	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	1/1/2013	12/31/2999
D4278	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	1/1/2013	12/31/2999
D4283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	autogenous connective tissue graft procedure (including donor and recipient surgical sites) ? each additional contiguous tooth, implant or edentulous tooth position in same graft site	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D4285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) ? each additional contiguous tooth, implant or edentulous tooth position in same graft site	1/1/2016	12/31/2999
D4322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	splint ? intra-coronal; natural teeth or prosthetic crowns	1/1/2022	12/31/2999
D4323	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	splint ? extra-coronal; natural teeth or prosthetic crowns	1/1/2022	12/31/2999
D4341	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodontal scaling and root planing - four or more teeth per quadrant	1/1/2013	12/31/2999
D4342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodontal scaling and root planing - one to three teeth per quadrant	1/1/2013	12/31/2999
D4346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scaling in presence of generalized moderate or severe gingival inflammation ? full mouth, after oral evaluation	1/1/2017	12/31/2999
D4355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	1/1/2013	12/31/2999
D4381	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	1/1/2013	12/31/2999
D4910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodontal maintenance	1/1/2013	12/31/2999
D4920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	unscheduled dressing change (by someone other than treating dentist or their staff)	1/1/2013	12/31/2999
D4921	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	gingival irrigation with a medicinal agent - per quadrant	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D4999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified periodontal procedure, by report	10/24/2019	12/31/2999
D5110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	complete denture - maxillary	1/1/2013	12/31/2999
D5120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	complete denture - mandibular	1/1/2013	12/31/2999
D5130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate denture - maxillary	1/1/2013	12/31/2999
D5140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate denture - mandibular	1/1/2013	12/31/2999
D5211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillary partial denture ? resin base (including any conventional clasps retentive/clasping materials, rests, and teeth)	1/1/2013	12/31/2999
D5212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	mandibular partial denture ? resin base (including any conventional clasps retentive/clasping materials, rests, and teeth)	1/1/2013	12/31/2999
D5213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1/1/2013	12/31/2999
D5214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1/1/2013	12/31/2999
D5221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate maxillary partial denture ? resin base (including retentive/clasping materials, rests and teeth) rebasing/relining procedure(s).	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D5222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate mandibular partial denture ? resin base (including retentive/clasping materials, rests and teeth) rebasing/relining procedure(s).	1/1/2016	12/31/2999
D5223	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate maxillary partial denture ? cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1/1/2016	12/31/2999
D5224	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate mandibular partial denture ? cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1/1/2016	12/31/2999
D5225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	maxillary partial denture - flexible base (including any clasps, rests and teeth)	1/1/2013	12/31/2999
D5226	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	mandibular partial denture - flexible base (including any clasps, rests and teeth)	1/1/2013	12/31/2999
D5227	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	1/1/2022	12/31/2999
D5228	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	1/1/2022	12/31/2999
D5282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable unilateral partial denture ? one piece cast metal (including clasps and teeth), maxillary	1/1/2019	12/31/2999
D5283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable unilateral partial denture ? one piece cast metal (including clasps and teeth), mandibular	1/1/2019	12/31/2999
D5284	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable unilateral partial denture ? one piece flexible base (including clasps and teeth) ? per quadrant	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D5286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable unilateral partial denture ? one piece resin (including clasps and teeth) ? per quadrant	1/1/2020	12/31/2999
D5410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	adjust complete denture - maxillary	1/1/2013	12/31/2999
D5411	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	adjust complete denture - mandibular	1/1/2013	12/31/2999
D5421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	adjust partial denture - maxillary	1/1/2013	12/31/2999
D5422	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	adjust partial denture - mandibular	1/1/2013	12/31/2999
D5520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replace missing or broken teeth - complete denture -per tooth	1/1/2013	12/31/2999
D5630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	repair or replace broken clasp retentive/clasping materials per tooth	1/1/2013	12/31/2999
D5640	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replace missing or broken teeth - partial denture - per tooth	1/1/2013	12/31/2999
D5650	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Add tooth to existing partial denture - per tooth	1/1/2013	12/31/2999
D5660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	add clasp to existing partial denture	1/1/2013	12/31/2999
D5670	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replace all teeth and acrylic on cast metal framework (maxillary)	1/1/2013	12/31/2999
D5671	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replace all teeth and acrylic on cast metal framework (mandibular)	1/1/2013	12/31/2999
D5710	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	rebase complete maxillary denture	1/1/2013	12/31/2999
D5711	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	rebase complete mandibular denture	1/1/2013	12/31/2999
D5720	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	rebase maxillary partial denture	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D5721	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	rebase mandibular partial denture	1/1/2013	12/31/2999
D5725	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	rebase hybrid prosthesis	1/1/2022	12/31/2999
D5730	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline complete maxillary denture (chairside)	1/1/2013	12/31/2999
D5731	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline complete mandibular denture (chairside)	1/1/2013	12/31/2999
D5740	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline maxillary partial denture (chairside)	1/1/2013	12/31/2999
D5741	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline mandibular partial denture (chairside)	1/1/2013	12/31/2999
D5750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline complete maxillary denture (laboratory)	1/1/2013	12/31/2999
D5751	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline complete mandibular denture (laboratory)	1/1/2013	12/31/2999
D5760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline maxillary partial denture (laboratory)	1/1/2013	12/31/2999
D5761	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	reline mandibular partial denture (laboratory)	1/1/2013	12/31/2999
D5765	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	soft liner for complete or partial removable denture ? indirect	1/1/2022	12/31/2999
D5810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim complete denture (maxillary)	1/1/2013	12/31/2999
D5811	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim complete denture (mandibular)	1/1/2013	12/31/2999
D5820	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim partial denture (maxillary)	1/1/2013	12/31/2999
D5821	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim partial denture (mandibular)	1/1/2013	12/31/2999
D5850	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	tissue conditioning, maxillary	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D5851	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	tissue conditioning, mandibular	1/1/2013	12/31/2999
D5862	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	precision attachment, by report	1/1/2013	12/31/2999
D5863	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Overdenture - complete maxillary - natural tooth borne	1/1/2014	12/31/2999
D5864	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Overdenture - partial maxillary - natural tooth borne	1/1/2014	12/31/2999
D5865	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Overdenture - complete mandibular - natural tooth borne	1/1/2014	12/31/2999
D5866	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Overdenture - partial mandibular - natural tooth borne	1/1/2014	12/31/2999
D5867	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replacement of replaceable part of semi-precision or precision attachment, per attachment of natural tooth borne prosthesis	1/1/2013	12/31/2999
D5875	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	modification of removable prosthesis following implant surgery	1/1/2013	12/31/2999
D5876	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Add metal substructure to acrylic complete denture- per arch	1/1/2019	12/31/2999
D5877	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	duplication of complete denture - maxillary	1/1/2026	12/31/2999
D5878	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	duplication of complete denture - mandibular	1/1/2026	12/31/2999
D5899	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified removable prosthodontic procedure, by report	10/24/2019	12/31/2999
D5937	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	trismus appliance (not for TMD treatment)	1/1/2013	12/31/2999
D5982	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical stent for soft tissue healing	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D5986	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fluoride gel carrier	1/1/2013	12/31/2999
D5988	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SURGICAL SPLINT	1/1/2013	12/31/2999
D5991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	vesiculobullous disease medicament carrier	1/1/2013	12/31/2999
D5995	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodontal medicament carrier with peripheral seal ? laboratory processed, maxillary	1/1/2021	12/31/2999
D5996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodontal medicament carrier with peripheral seal ? laboratory processed, mandibular	1/1/2021	12/31/2999
D5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified maxillofacial prosthesis, by report	10/24/2019	12/31/2999
D6010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical placement of implant body: endosteal implant	1/1/2013	12/31/2999
D6011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical access to an implant body (second stage implant surgery)	1/1/2014	12/31/2999
D6012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	1/1/2013	12/31/2999
D6013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical placement of mini implant	1/1/2014	12/31/2999
D6040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical placement: eposteal implant	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	1/1/2026	12/31/2999
D6050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical placement: transosteal implant	1/1/2013	12/31/2999
D6055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	connecting bar ? implant supported or abutment supported	1/1/2013	12/31/2999
D6056	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	prefabricated abutment ? includes modification and placement	1/1/2013	12/31/2999
D6057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	custom fabricated abutment ? includes placement	1/1/2013	12/31/2999
D6058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported porcelain/ceramic crown	1/1/2013	12/31/2999
D6059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported porcelain fused to metal crown (high noble metal)	1/1/2013	12/31/2999
D6060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported porcelain fused to metal crown (predominantly base metal)	1/1/2013	12/31/2999
D6061	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported porcelain fused to metal crown (noble metal)	1/1/2013	12/31/2999
D6062	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported cast metal crown (high noble metal)	1/1/2013	12/31/2999
D6063	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported cast metal crown (predominantly base metal)	1/1/2013	12/31/2999
D6064	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported cast metal crown (noble metal)	1/1/2013	12/31/2999
D6065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported porcelain/ceramic crown	1/1/2013	12/31/2999
D6066	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? porcelain fused to high noble alloys	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? high noble alloys	1/1/2013	12/31/2999
D6068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for porcelain/ceramic FPD	1/1/2013	12/31/2999
D6069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	1/1/2013	12/31/2999
D6070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	1/1/2013	12/31/2999
D6071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for porcelain fused to metal FPD (noble metal)	1/1/2013	12/31/2999
D6072	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for cast metal FPD (high noble metal)	1/1/2013	12/31/2999
D6073	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for cast metal FPD (predominantly base metal)	1/1/2013	12/31/2999
D6074	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer for cast metal FPD (noble metal)	1/1/2013	12/31/2999
D6075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for ceramic FPD	1/1/2013	12/31/2999
D6076	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for FPD ? porcelain fused to high noble alloys	1/1/2013	12/31/2999
D6077	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for metal FPD ? high noble alloys	1/1/2013	12/31/2999
D6080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6081	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	1/1/2017	12/31/2999
D6082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? porcelain fused to predominantly base alloys	1/1/2020	12/31/2999
D6083	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? porcelain fused to noble alloys	1/1/2020	12/31/2999
D6084	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6085	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim implant crown	1/1/2017	12/31/2999
D6086	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? predominantly base alloys	1/1/2020	12/31/2999
D6087	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? noble alloys	1/1/2020	12/31/2999
D6088	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported crown ? titanium and titanium alloys	1/1/2020	12/31/2999
D6091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	1/1/2013	12/31/2999
D6094	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported crown ? titanium and titanium alloys	1/1/2013	12/31/2999
D6097	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported crown ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6098	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer ? porcelain fused to predominantly base alloys	1/1/2020	12/31/2999
D6099	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for FPD ? porcelain fused to noble alloys	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of implant body not requiring bone removal nor flap elevation	1/1/2023	12/31/2999
D6110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported removable denture for edentulous arch ? maxillary	1/1/2015	12/31/2999
D6111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported removable denture for edentulous arch ? mandibular	1/1/2015	12/31/2999
D6112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported removable denture for partially edentulous arch ? maxillary	1/1/2015	12/31/2999
D6113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported removable denture for partially edentulous arch ? mandibular	1/1/2015	12/31/2999
D6114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported fixed denture for edentulous arch ? maxillary	1/1/2015	12/31/2999
D6115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported fixed denture for edentulous arch ? mandibular	1/1/2015	12/31/2999
D6116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported fixed denture for partially edentulous arch ? maxillary	1/1/2015	12/31/2999
D6117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant /abutment supported fixed denture for partially edentulous arch ? mandibular	1/1/2015	12/31/2999
D6120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for metal FPD ? predominantly base alloys	1/1/2020	12/31/2999
D6122	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for metal FPD ? noble alloys	1/1/2020	12/31/2999
D6123	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant supported retainer for metal FPD ? titanium and titanium alloys	1/1/2020	12/31/2999
D6191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	semi-precision abutment - placement	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6192	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	semi-precision attachment - placement	1/1/2021	12/31/2999
D6194	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer crown for FPD ? titanium and titanium alloys	1/1/2013	12/31/2999
D6195	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	abutment supported retainer ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6196	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of an indirect restoration on an implant retained abutment	1/1/2026	12/31/2999
D6197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	1/1/2023	12/31/2999
D6198	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	remove interim implant component	1/1/2022	12/31/2999
D6199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified implant procedure, by report	10/24/2019	12/31/2999
D6205	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PONTIC - INDIRECT RESIN BASED COMPOSITE	1/1/2013	12/31/2999
D6210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - cast high noble metal	1/1/2013	12/31/2999
D6211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - cast predominantly base metal	1/1/2013	12/31/2999
D6212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - cast noble metal	1/1/2013	12/31/2999
D6214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic ? titanium and titanium alloys	1/1/2013	12/31/2999
D6240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - porcelain fused to high noble metal	1/1/2013	12/31/2999
D6241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - porcelain fused to predominantly base metal	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - porcelain fused to noble metal	1/1/2013	12/31/2999
D6243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - porcelain/ceramic	1/1/2013	12/31/2999
D6250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - resin with high noble metal	1/1/2013	12/31/2999
D6251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - resin with predominantly base metal	1/1/2013	12/31/2999
D6252	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pontic - resin with noble metal	1/1/2013	12/31/2999
D6253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	interim pontic ? further treatment or completion of diagnosis necessary prior to final impression	1/1/2013	12/31/2999
D6280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch	1/1/2026	12/31/2999
D6545	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retainer - cast metal for resin bonded fixed prosthesis	1/1/2013	12/31/2999
D6548	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retainer - porcelain/ceramic for resin bonded fixed prosthesis	1/1/2013	12/31/2999
D6549	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	resin retainer ? for resin bonded fixed prosthesis	1/1/2015	12/31/2999
D6600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - porcelain/ceramic, two surfaces	1/1/2013	12/31/2999
D6601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - porcelain/ceramic, three or more surfaces	1/1/2013	12/31/2999
D6602	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast high noble metal, two surfaces	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6603	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast high noble metal, three or more surfaces	1/1/2013	12/31/2999
D6604	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast predominantly base metal, two surfaces	1/1/2013	12/31/2999
D6605	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast predominantly base metal, three or more surfaces	1/1/2013	12/31/2999
D6606	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast noble metal, two surfaces	1/1/2013	12/31/2999
D6607	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	inlay - cast noble metal, three or more surfaces	1/1/2013	12/31/2999
D6608	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay -porcelain/ceramic, two surfaces	1/1/2013	12/31/2999
D6609	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - porcelain/ceramic, three or more surfaces	1/1/2013	12/31/2999
D6610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast high noble metal, two surfaces	1/1/2013	12/31/2999
D6611	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast high noble metal, three or more surfaces	1/1/2013	12/31/2999
D6612	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast predominantly base metal, two surfaces	1/1/2013	12/31/2999
D6613	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast predominantly base metal, three or more surfaces	1/1/2013	12/31/2999
D6614	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast noble metal, two surfaces	1/1/2013	12/31/2999
D6615	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	onlay - cast noble metal, three or more surfaces	1/1/2013	12/31/2999
D6624	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INLAY - TITANIUM	1/1/2013	12/31/2999
D6634	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONLAY - TITANIUM	1/1/2013	12/31/2999
D6710	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CROWN - INDIRECT RESIN BASED COMPOSITE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6720	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with high noble metal	1/1/2013	12/31/2999
D6721	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with predominantly base metal	1/1/2013	12/31/2999
D6722	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - resin with noble metal	1/1/2013	12/31/2999
D6740	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain/ceramic	1/1/2013	12/31/2999
D6750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to high noble metal	1/1/2013	12/31/2999
D6751	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to predominantly base metal	1/1/2013	12/31/2999
D6752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - porcelain fused to noble metal	1/1/2013	12/31/2999
D6753	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retainer crown ? porcelain fused to titanium and titanium alloys	1/1/2020	12/31/2999
D6780	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast high noble metal	1/1/2013	12/31/2999
D6781	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast predominantly base metal	1/1/2013	12/31/2999
D6782	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 cast noble metal	1/1/2013	12/31/2999
D6783	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - 3/4 porcelain/ceramic	1/1/2013	12/31/2999
D6784	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retainer crown ¾ ? titanium and titanium alloys	1/1/2020	12/31/2999
D6790	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast high noble metal	1/1/2013	12/31/2999
D6791	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast predominantly base metal	1/1/2013	12/31/2999
D6792	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	crown - full cast noble metal	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D6794	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	retainer crown ? titanium and titanium alloys	1/1/2013	12/31/2999
D6920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	connector bar	1/1/2013	12/31/2999
D6930	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond fixed partial denture	1/1/2013	12/31/2999
D6940	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	STRESS BREAKER	1/1/2013	12/31/2999
D6950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PRECISION ATTACHMENT	1/1/2013	12/31/2999
D6980	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fixed partial denture repair necessitated by restorative material failure	1/1/2013	12/31/2999
D6985	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pediatric partial denture, fixed	1/1/2013	12/31/2999
D6999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified fixed prosthodontic procedure, by report	10/24/2019	12/31/2999
D7111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extraction, coronal remnants ? primary tooth	1/1/2013	12/31/2999
D7140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1/1/2013	12/31/2999
D7210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1/1/2013	12/31/2999
D7220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of impacted tooth - soft tissue	1/1/2013	12/31/2999
D7230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of impacted tooth - partially bony	1/1/2013	12/31/2999
D7250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of residual tooth roots (cutting procedure)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	coronectomy - intentional partial tooth removal, impacted teeth only	1/1/2013	12/31/2999
D7272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	1/1/2013	12/31/2999
D7280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	exposure of an unerupted tooth	1/1/2013	12/31/2999
D7282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	mobilization of erupted or malpositioned tooth to aid eruption	1/1/2013	12/31/2999
D7283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	1/1/2013	12/31/2999
D7287	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	exfoliative cytological sample collection	1/1/2013	12/31/2999
D7288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	1/1/2013	12/31/2999
D7290	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical repositioning of teeth	1/1/2013	12/31/2999
D7291	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	transseptal fiberotomy/supra crestal fiberotomy, by report	1/1/2013	12/31/2999
D7292	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	placement of temporary anchorage device [screw retained plate] requiring flap;	1/1/2013	12/31/2999
D7293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	placement of temporary anchorage device requiring flap;	1/1/2013	12/31/2999
D7294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	placement of temporary anchorage device without flap;	1/1/2013	12/31/2999
D7310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	alveoloplasty in conjunction with extractions four or more teeth or tooth spaces, per quadrant	1/1/2013	12/31/2999
D7311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces, per quadrant	1/1/2013	12/31/2999
D7321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1/1/2013	12/31/2999
D7340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	vestibuloplasty - ridge extension (secondary epithelialization)	1/1/2013	12/31/2999
D7350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	1/1/2013	12/31/2999
D7450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	1/1/2013	12/31/2999
D7451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	1/1/2013	12/31/2999
D7472	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of torus palatinus	1/1/2013	12/31/2999
D7473	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removal of torus mandibularis	1/1/2013	12/31/2999
D7510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	incision and drainage of abscess - intraoral soft tissue	1/1/2013	12/31/2999
D7810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	open reduction of dislocation	1/1/2013	12/31/2999
D7820	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	closed reduction of dislocation	1/1/2013	12/31/2999
D7830	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	manipulation under anesthesia	1/1/2013	12/31/2999
D7840	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	condylectomy	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7850	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	surgical discectomy, with/without implant	1/1/2013	12/31/2999
D7852	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	disc repair	1/1/2013	12/31/2999
D7854	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	synovectomy	1/1/2013	12/31/2999
D7856	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	myotomy	1/1/2013	12/31/2999
D7858	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	joint reconstruction	1/1/2013	12/31/2999
D7860	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthrotomy	1/1/2013	12/31/2999
D7865	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroplasty	1/1/2013	12/31/2999
D7870	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthrocentesis	1/1/2013	12/31/2999
D7871	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	non-arthroscopic lysis and lavage	1/1/2013	12/31/2999
D7872	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy - diagnosis, with or without biopsy	1/1/2013	12/31/2999
D7873	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy: lavage and lysis of adhesions	1/1/2013	12/31/2999
D7874	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy: disc repositioning and stabilization	1/1/2013	12/31/2999
D7875	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy: synovectomy	1/1/2013	12/31/2999
D7876	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy: discectomy	1/1/2013	12/31/2999
D7877	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	arthroscopy: debridement	1/1/2013	12/31/2999
D7880	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal orthotic device, by report	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D7881	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal orthotic device adjustment	1/1/2016	12/31/2999
D7921	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	collection and application of autologous blood concentrate product	1/1/2013	12/31/2999
D7939	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	1/1/2024	12/31/2999
D7950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	1/1/2013	12/31/2999
D7951	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	sinus augmentation with bone or bone substitutes via a lateral open approach	1/1/2013	12/31/2999
D7953	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	bone replacement graft for ridge preservation - per site	1/1/2013	12/31/2999
D7970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	excision of hyperplastic tissue - per arch	1/1/2013	12/31/2999
D7971	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	excision of pericoronal gingiva	1/1/2013	12/31/2999
D7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified oral surgery procedure, by report	10/24/2019	12/31/2999
D8010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	limited orthodontic treatment of the primary dentition	1/1/2013	12/31/2999
D8020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	limited orthodontic treatment of the transitional dentition	1/1/2013	12/31/2999
D8030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	limited orthodontic treatment of the adolescent dentition	1/1/2013	12/31/2999
D8040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	limited orthodontic treatment of the adult dentition	1/1/2013	12/31/2999
D8070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	comprehensive orthodontic treatment of the transitional dentition	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D8080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	comprehensive orthodontic treatment of the adolescent dentition	1/1/2013	12/31/2999
D8090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	comprehensive orthodontic treatment of the adult dentition	1/1/2013	12/31/2999
D8091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive orthodontic treatment with orthognathic surgery	1/1/2025	12/31/2999
D8210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable appliance therapy	1/1/2013	12/31/2999
D8220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fixed appliance therapy	1/1/2013	12/31/2999
D8660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pre-orthodontic treatment examination to monitor growth and development	1/1/2013	12/31/2999
D8670	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	periodic orthodontic treatment visit	1/1/2013	12/31/2999
D8671	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Periodic orthodontic treatment visit associated with orthognathic surgery	1/1/2025	12/31/2999
D8680	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	orthodontic retention (removal of appliances, construction and placement of retainer(s))	1/1/2013	12/31/2999
D8681	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	removable orthodontic retainer adjustment	1/1/2016	12/31/2999
D8696	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	repair of orthodontic appliance ? maxillary	1/1/2020	12/31/2999
D8697	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	repair of orthodontic appliance ? mandibular	1/1/2020	12/31/2999
D8698	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond fixed retainer ? maxillary	1/1/2020	12/31/2999
D8699	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	re-cement or re-bond fixed retainer ? mandibular	1/1/2020	12/31/2999
D8701	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	repair of fixed retainer, includes reattachment ? maxillary	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D8702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	repair of fixed retainer, includes reattachment ? mandibular	1/1/2020	12/31/2999
D8703	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replacement of lost or broken retainer ? maxillary	1/1/2020	12/31/2999
D8704	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	replacement of lost or broken retainer ? mandibular	1/1/2020	12/31/2999
D8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified orthodontic procedure, by report	10/24/2019	12/31/2999
D9110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	palliative treatment of dental pain - per visit	1/1/2013	12/31/2999
D9120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FIXED PARTIAL DENTURE SECTIONING	1/1/2013	12/31/2999
D9128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	photobiomodulation therapy - first 15 minute increment, or any portion thereof	1/1/2026	12/31/2999
D9129	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof	1/1/2026	12/31/2999
D9130	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	temporomandibular joint dysfunction ? non-invasive physical therapies	1/1/2019	12/31/2999
D9211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REGIONAL BLOCK ANESTHESIA	1/1/2013	12/31/2999
D9212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	trigeminal division block anesthesia	1/1/2013	12/31/2999
D9215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	local anesthesia in conjunction with operative or surgical procedures	1/1/2013	12/31/2999
D9219	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	evaluation for moderate sedation, deep sedation or general anesthesia	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	1/1/2026	12/31/2999
D9225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof	1/1/2026	12/31/2999
D9230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Administration of nitrous oxide	1/1/2013	12/31/2999
D9243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Administration of moderate sedation - intravenous - each subsequent 15 minute increment or any portion thereof	1/1/2016	12/31/2999
D9310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN	1/1/2013	12/31/2999
D9311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Consultation with a medical health care professional	1/1/2017	12/31/2999
D9410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	house/extended care facility call	1/1/2013	12/31/2999
D9420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	hospital or ambulatory surgical center call	1/1/2013	12/31/2999
D9430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	office visit for observation (during regularly scheduled hours) - no other services performed	1/1/2013	12/31/2999
D9440	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	office visit - after regularly scheduled hours	1/1/2013	12/31/2999
D9450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	case presentation, subsequent to detailed and extensive treatment planning	1/1/2013	12/31/2999
D9610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	therapeutic parenteral drug, single administration	1/1/2013	12/31/2999
D9612	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	therapeutic parenteral drugs, two or more administrations, different medications	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9613	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	infiltration of sustained release therapeutic drug, per quadrant	1/1/2019	12/31/2999
D9630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	drugs or medicaments dispensed in the office for home use	1/1/2013	12/31/2999
D9910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	application of desensitizing medicament	1/1/2013	12/31/2999
D9911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	application of desensitizing resin for cervical and/or root surface, per tooth	1/1/2013	12/31/2999
D9912	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	pre-visit patient screening	1/1/2022	12/31/2999
D9913	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	administration of neuromodulators	1/1/2025	12/31/2999
D9914	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	administration dermal fillers	1/1/2025	12/31/2999
D9920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	behavior management, by report	1/1/2013	12/31/2999
D9932	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of removable complete denture, maxillary	1/1/2016	12/31/2999
D9933	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of removable complete denture, mandibular	1/1/2016	12/31/2999
D9934	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of removable partial denture, maxillary	1/1/2016	12/31/2999
D9935	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of removable partial denture, mandibular	1/1/2016	12/31/2999
D9936	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cleaning and inspection of occlusal guard - per appliance	1/1/2026	12/31/2999
D9938	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fabrication of a custom removable clear plastic temporary aesthetic appliance	1/1/2024	12/31/2999
D9939	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	placement of a custom removable clear plastic temporary aesthetic appliance	1/1/2024	12/31/2999
D9941	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	fabrication of athletic mouthguard	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9942	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	1/1/2013	12/31/2999
D9943	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal guard adjustment	1/1/2016	12/31/2999
D9944	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal guard ? hard appliance, full arch	1/1/2019	12/31/2999
D9945	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal guard ? soft appliance, full arch	1/1/2019	12/31/2999
D9946	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal guard ? hard appliance, partial arch	1/1/2019	12/31/2999
D9947	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	custom sleep apnea appliance fabrication and placement	1/1/2022	12/31/2999
D9948	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	adjustment of custom sleep apnea appliance	1/1/2022	12/31/2999
D9949	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	repair of custom sleep apnea appliance	1/1/2022	12/31/2999
D9950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusion analysis - mounted case	1/1/2013	12/31/2999
D9951	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal adjustment - limited	1/1/2013	12/31/2999
D9952	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	occlusal adjustment - complete	1/1/2013	12/31/2999
D9954	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	1/1/2024	12/31/2999
D9955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	oral appliance therapy (OAT) titration visit	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9956	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	administration of home sleep apnea test	1/1/2024	12/31/2999
D9957	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	screening for sleep related breathing disorders	1/1/2024	12/31/2999
D9959	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	unspecified sleep apnea services procedure, by report	1/1/2025	12/31/2999
D9961	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	duplicate/copy patient's records	1/1/2019	12/31/2999
D9970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ENAMEL MICROABRASION	1/1/2013	12/31/2999
D9971	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	odontoplasty 1 - 2 teeth; includes removal of enamel projections	1/1/2013	12/31/2999
D9972	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	external bleaching ? per arch ? performed in office	1/1/2013	12/31/2999
D9973	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	external bleaching - per tooth	1/1/2013	12/31/2999
D9974	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	internal bleaching - per tooth	1/1/2013	12/31/2999
D9975	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	external bleaching for home application, per arch; includes materials and fabrication of custom trays	1/1/2013	12/31/2999
D9985	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	sales tax	1/1/2014	12/31/2999
D9986	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	missed appointment	1/1/2015	12/31/2999
D9987	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	cancelled appointment	1/1/2015	12/31/2999
D9990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	certified translation or sign-language services per visit	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
D9991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dental case management - addressing appointment compliance barriers	1/1/2017	12/31/2999
D9992	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dental case management ? care coordination	1/1/2017	12/31/2999
D9993	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dental case management - motivational interviewing	1/1/2017	12/31/2999
D9994	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dental case management - patient education to improve oral health literacy	1/1/2017	12/31/2999
D9995	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Teledentistry - synchronous; real-time encounter	1/1/2018	12/31/2999
D9996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	1/1/2018	12/31/2999
D9997	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	dental case management ? patients with special health care needs	1/1/2020	12/31/2999
D9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	unspecified adjunctive procedure, by report	1/1/1950	12/31/2999
D9999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	unspecified adjunctive procedure, by report	10/1/2013	12/31/2999
E0152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Walker, battery powered, wheeled, folding, adjustable or fixed height	4/1/2024	12/31/2999
E0170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM, ELECTRIC, ANY TYPE	2/15/2016	12/31/2999
E0172	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET, ANY TYPE	1/1/2021	12/31/2999
E0183	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty	10/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	1/1/2022	12/31/2999
E0201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Penile contracture device, manual, greater than 3 lbs traction force	4/1/2025	12/31/2999
E0210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electric heat pad, standard	1/1/2022	12/31/2999
E0215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electric heat pad, moist	1/1/2022	12/31/2999
E0217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Water circulating heat pad with pump	1/1/2021	12/31/2999
E0218	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fluid circulating cold pad with pump, any type	1/1/2021	12/31/2999
E0221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infrared heating pad system	10/1/2025	12/31/2999
E0225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hydrocollator unit, includes pads	1/1/2021	12/31/2999
E0231	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover	2/15/2015	12/31/2999
E0232	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Warming card for use with the non contact wound warming device and non contact wound warming wound cover	2/15/2015	12/31/2999
E0236	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pump for water circulating pad	1/1/2021	12/31/2999
E0239	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hydrocollator unit, portable	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub wall rail, each	1/1/2022	12/31/2999
E0242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bath tub rail, floor base	1/1/2022	12/31/2999
E0243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Toilet rail, each	1/1/2022	12/31/2999
E0249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY	1/1/2021	12/31/2999
E0270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress	9/1/2020	12/31/2999
E0273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bed board	1/1/2021	12/31/2999
E0274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Over-bed table	1/1/2020	12/31/2999
E0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	9/1/2020	12/31/2999
E0315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bed accessory: board, table, or support device, any type	1/1/2021	12/31/2999
E0316	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Safety enclosure frame/canopy for use with hospital bed, any type	9/1/2020	12/31/2999
E0328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD,	5/15/2022	12/31/2999
E0329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES,	5/15/2022	12/31/2999
E0445	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oximeter device for measuring blood oxygen levels non-invasively	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0446	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	9/1/2020	12/31/2999
E0446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	10/24/2019	12/31/2999
E0468	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions	4/1/2024	12/31/2999
E0481	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intrapulmonary percussive ventilation system and related accessories	1/1/2013	12/31/2999
E0482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cough stimulating device, alternating positive and negative airway pressure	1/1/2013	12/31/2999
E0483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each	1/1/2013	12/31/2999
E0484	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oscillatory positive expiratory pressure device, non-electric, any type, each	1/1/2013	12/31/2999
E0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0486	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	1/1/2013	12/31/2999
E0487	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES	2/15/2015	12/31/2999
E0490	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	10/1/2023	12/31/2999
E0491	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply	10/1/2023	12/31/2999
E0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	1/1/2024	12/31/2999
E0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0530	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	1/1/2024	12/31/2999
E0616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable cardiac event recorder with memory, activator and programmer	1/1/2013	12/31/2999
E0621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sling or seat, patient lift, canvas or nylon	9/1/2020	12/31/2999
E0625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, bathroom or toilet, not otherwise classified	1/1/2013	12/31/2999
E0625	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient lift, bathroom or toilet, not otherwise classified	12/21/2004	12/31/2999
E0627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat lift mechanism, electric, any type	1/1/2013	12/31/2999
E0629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat lift mechanism, non-electric, any type	1/1/2013	12/31/2999
E0630	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)	2/15/2016	12/31/2999
E0635	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient lift, electric with seat or sling	1/1/2021	12/31/2999
E0636	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Multipositional patient support system, with integrated lift, patient accessible controls	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0637	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS	1/1/2013	12/31/2999
E0638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	1/1/2013	12/31/2999
E0639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	1/1/2013	12/31/2999
E0640	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient lift, fixed system, includes all components/accessories	1/1/2021	12/31/2999
E0641	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	1/1/2013	12/31/2999
E0642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC	1/1/2013	12/31/2999
E0650	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, non-segmental home model	1/1/2013	12/31/2999
E0651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, segmental home model without calibrated gradient pressure	1/1/2013	12/31/2999
E0652	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compressor, segmental home model with calibrated gradient pressure	1/1/2013	12/31/2999
E0655	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0656	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	1/1/2013	12/31/2999
E0657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	1/1/2013	12/31/2999
E0658	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest	10/1/2025	12/31/2999
E0659	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest	10/1/2025	12/31/2999
E0660	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	1/1/2013	12/31/2999
E0665	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	1/1/2013	12/31/2999
E0666	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	1/1/2013	12/31/2999
E0667	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, full leg	1/1/2013	12/31/2999
E0668	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, full arm	1/1/2013	12/31/2999
E0669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, half leg	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0670	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	1/1/2013	12/31/2999
E0671	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, full leg	1/1/2013	12/31/2999
E0672	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, full arm	1/1/2013	12/31/2999
E0673	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Segmental gradient pressure pneumatic appliance, half leg	1/1/2013	12/31/2999
E0675	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	1/1/2026	12/31/2999
E0676	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	1/1/2013	12/31/2999
E0676	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	3/20/2019	12/31/2999
E0677	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, trunk	7/1/2023	12/31/2999
E0678	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, full leg	1/1/2024	12/31/2999
E0679	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, half leg	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0680	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic compression controller with sequential calibrated gradient pressure	1/1/2024	12/31/2999
E0681	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic compression controller without calibrated gradient pressure	1/1/2024	12/31/2999
E0682	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic sequential compression garment, full arm	1/1/2024	12/31/2999
E0683	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-pneumatic, non-sequential, peristaltic wave compression pump	10/1/2024	12/31/2999
E0691	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	4/1/2015	12/31/2999
E0692	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	4/1/2015	12/31/2999
E0693	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel	4/1/2015	12/31/2999
E0694	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection	4/1/2015	12/31/2999
E0715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	10/1/2024	12/31/2999
E0716	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION	1/1/2013	12/31/2999
E0721	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcutaneous electrical nerve stimulator for nerves in the auricular region	5/15/2025	12/31/2999
E0730	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	1/1/2013	12/31/2999
E0731	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Form fitting conductive garment for delivery of tens or nmes (with conductive fibers separated from the patient's skin by layers of fabric)	5/15/2019	12/31/2999
E0732	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cranial electrotherapy stimulation (ces) system, any type	5/15/2024	12/31/2999
E0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	1/1/2024	12/31/2999
E0734	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	External upper limb tremor stimulator of the peripheral nerves of the wrist	5/15/2024	12/31/2999
E0735	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-invasive vagus nerve stimulator	1/1/2024	12/31/2999
E0736	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous tibial nerve stimulator	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0737	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcutaneous tibial nerve stimulator, controlled by phone application	10/1/2024	12/31/2999
E0738	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories	5/15/2025	12/31/2999
E0739	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors	4/1/2024	12/31/2999
E0740	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Non-implanted pelvic floor electrical stimulator, complete system	2/15/2015	12/31/2999
E0744	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromuscular stimulator for scoliosis	1/1/2013	12/31/2999
E0745	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neuromuscular stimulator, electronic shock unit	1/1/2013	12/31/2999
E0746	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electromyography (emg), biofeedback device	1/1/2020	12/31/2999
E0747	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	1/1/2013	12/31/2999
E0748	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, electrical, non-invasive, spinal applications	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0749	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, electrical, surgically implanted	1/1/2013	12/31/2999
E0760	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Osteogenesis stimulator, low intensity ultrasound, non-invasive	1/1/2013	12/31/2999
E0761	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	1/1/2013	12/31/2999
E0762	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	2/15/2015	12/31/2999
E0764	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	4/15/2022	12/31/2999
E0765	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fda approved nerve stimulator, for treatment of nausea and vomiting	1/1/2013	12/31/2999
E0766	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulation device used for cancer treatment, includes all accessories, any type	6/15/2017	12/31/2999
E0769	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	1/1/2005	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0769	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	2/15/2015	12/31/2999
E0770	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	9/1/2020	12/31/2999
E0770	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	1/1/2009	12/31/2999
E0787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing	1/1/2020	12/31/2999
E0830	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ambulatory traction device, all types, each	2/15/2015	12/31/2999
E0840	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction frame, attached to headboard, cervical traction	2/15/2015	12/31/2999
E0849	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0850	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction stand, free standing, cervical traction	2/15/2015	12/31/2999
E0855	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical traction equipment not requiring additional stand or frame	2/15/2015	12/31/2999
E0856	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical traction device, with inflatable air bladder(s)	2/15/2015	12/31/2999
E0860	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction equipment, overdoor, cervical	2/15/2015	12/31/2999
E0890	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Traction frame, attached to footboard, pelvic traction	2/15/2015	12/31/2999
E0935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY	1/1/2013	12/31/2999
E0936	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE	12/1/2020	12/31/2999
E0942	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cervical head harness/halter	2/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0944	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pelvic belt/harness/boot	2/15/2015	12/31/2999
E0950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, tray, each	6/1/2015	12/31/2999
E0955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	1/1/2013	12/31/2999
E0958	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, one-arm drive attachment, each	6/15/2017	12/31/2999
E0961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, wheel lock brake extension (handle), each	11/15/2020	12/31/2999
E0968	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Commode seat, wheelchair	11/15/2020	12/31/2999
E0969	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Narrowing device, wheelchair	6/1/2015	12/31/2999
E0971	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, ANTI-TIPPING DEVICE, EACH	11/15/2020	12/31/2999
E0973	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	11/15/2020	12/31/2999
E0974	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, anti-rollback device, each	6/15/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E0981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, seat upholstery, replacement only, each	1/1/2013	12/31/2999
E0982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, back upholstery, replacement only, each	1/1/2013	12/31/2999
E0983	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	1/1/2013	12/31/2999
E0984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control	1/1/2013	12/31/2999
E0985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, seat lift mechanism	6/1/2015	12/31/2999
E0986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, power assist system	6/1/2015	12/31/2999
E0988	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	6/1/2015	12/31/2999
E0990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, elevating leg rest, complete assembly, each	6/1/2015	12/31/2999
E0992	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid seat insert	1/1/2013	12/31/2999
E1002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, tilt only	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1003	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, recline only, without shear reduction	1/1/2013	12/31/2999
E1004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	1/1/2013	12/31/2999
E1005	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seatng system, recline only, with power shear reduction	1/1/2013	12/31/2999
E1006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	1/1/2013	12/31/2999
E1007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	1/1/2013	12/31/2999
E1008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	1/1/2013	12/31/2999
E1009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	1/1/2013	12/31/2999
E1010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	1/1/2013	12/31/2999
E1012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	1/1/2016	12/31/2999
E1014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Reclining back, addition to pediatric size wheelchair	6/15/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Wheelchair transportation securement system, any type includes all components and accessories	4/1/2025	12/31/2999
E1023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Wheelchair transit securement system, includes all components and accessories	4/1/2025	12/31/2999
E1028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other	6/1/2015	12/31/2999
E1031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rollabout chair, any and all types with castors 5 or greater	6/1/2015	12/31/2999
E1032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface	4/1/2025	12/31/2999
E1033	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type	4/1/2025	12/31/2999
E1034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type	4/1/2025	12/31/2999
E1035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	1/1/2013	12/31/2999
E1036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transport chair, pediatric size	6/1/2015	12/31/2999
E1038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	6/1/2015	12/31/2999
E1039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY GREATER THAN 300 POUNDS	1/1/2013	12/31/2999
E1050	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1060	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating legrests	6/1/2015	12/31/2999
E1070	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable footrest	6/1/2015	12/31/2999
E1083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest	6/1/2015	12/31/2999
E1084	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1085	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	6/1/2015	12/31/2999
E1086	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hemi-wheelchair detachable arms desk or full length, swing away detachable footrests	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1087	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1088	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1089	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, fixed length arms, swing away detachable footrest	6/1/2015	12/31/2999
E1090	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests	6/1/2015	12/31/2999
E1092	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1093	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable footrests	6/1/2015	12/31/2999
E1100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	6/1/2015	12/31/2999
E1110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Semi-reclining wheelchair, detachable arms (desk or full length) elevating leg rest	6/1/2015	12/31/2999
E1130	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	6/1/2015	12/31/2999
E1140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, detachable arms, desk or full length, swing away detachable footrests	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, detachable arms, desk or full length swing away detachable elevating legrests	6/1/2015	12/31/2999
E1160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, fixed full length arms, swing away detachable elevating legrests	6/1/2015	12/31/2999
E1161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual adult size wheelchair, includes tilt in space	6/1/2015	12/31/2999
E1170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests	6/1/2015	12/31/2999
E1171	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, without footrests or legrest	6/1/2015	12/31/2999
E1172	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest	6/1/2015	12/31/2999
E1180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests	6/1/2015	12/31/2999
E1190	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating legrests	6/1/2015	12/31/2999
E1195	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests	1/1/2013	12/31/2999
E1200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amputee wheelchair, fixed full length arms, swing away detachable footrest	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification	1/1/2013	12/31/2999
E1221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with fixed arm, footrests	6/1/2015	12/31/2999
E1222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with fixed arm, elevating legrests	6/1/2015	12/31/2999
E1223	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with detachable arms, footrests	6/1/2015	12/31/2999
E1224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair with detachable arms, elevating legrests	6/1/2015	12/31/2999
E1225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	6/1/2015	12/31/2999
E1226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each	1/1/2013	12/31/2999
E1227	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special height arms for wheelchair	6/1/2015	12/31/2999
E1228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special back height for wheelchair	6/1/2015	12/31/2999
E1229	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1229	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power operated vehicle (three or four wheel nonhighway) specify brand name and model number	1/1/2013	12/31/2999
E1231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	1/1/2013	12/31/2999
E1232	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system	1/1/2013	12/31/2999
E1233	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system	1/1/2013	12/31/2999
E1234	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system	1/1/2013	12/31/2999
E1235	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, rigid, adjustable, with seating system	6/1/2015	12/31/2999
E1236	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, folding, adjustable, with seating system	6/1/2015	12/31/2999
E1237	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, rigid, adjustable, without seating system	6/1/2015	12/31/2999
E1238	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair, pediatric size, folding, adjustable, without seating system	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1239	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	6/1/2015	12/31/2999
E1239	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	1/1/2005	12/31/2999
E1240	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest	6/1/2015	12/31/2999
E1250	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, fixed full length arms, swing away detachable footrest	6/1/2015	12/31/2999
E1260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest	6/1/2015	12/31/2999
E1270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests	6/1/2015	12/31/2999
E1280	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, detachable arms (desk or full length) elevating legrests	1/1/2013	12/31/2999
E1285	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	1/1/2013	12/31/2999
E1290	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest	1/1/2013	12/31/2999
E1295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair, fixed full length arms, elevating legrest	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1296	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat height from floor	6/1/2015	12/31/2999
E1297	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat depth, by upholstery	6/1/2015	12/31/2999
E1298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Special wheelchair seat depth and/or width, by construction	6/1/2015	12/31/2999
E1300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, portable (overtub type)	6/1/2015	12/31/2999
E1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool tub, walk-in, portable	1/1/2024	12/31/2999
E1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Whirlpool, non-portable (built-in type)	6/1/2015	12/31/2999
E1399	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Durable medical equipment, miscellaneous	1/15/2015	12/31/2999
E1570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adjustable chair, for esrd patients	1/1/2022	12/31/2999
E1632	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Wearable artificial kidney, each	1/1/2023	12/31/2999
E1639	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scale, each	1/1/2022	12/31/2999
E1699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dialysis equipment, not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E1700	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Jaw motion rehabilitation system	6/1/2024	12/31/2999
E1701	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replacement cushions for jaw motion rehabilitation system, pkg. Of 6	6/1/2024	12/31/2999
E1702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200	6/1/2024	12/31/2999
E1902	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Communication board, non-electronic augmentative or alternative communication device	1/1/2021	12/31/2999
E1905	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Virtual reality cognitive behavioral therapy device (cbt), including pre-programmed therapy software	5/15/2025	12/31/2999
E2120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pulse generator system for tympanic treatment of inner ear endolymphatic fluid	9/1/2020	12/31/2999
E2201	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	6/1/2015	12/31/2999
E2202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches	6/1/2015	12/31/2999
E2203	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	6/1/2015	12/31/2999
E2204	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	6/1/2015	12/31/2999
E2206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	1/1/2021	12/31/2999
E2209	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	6/1/2015	12/31/2999
E2211	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2212	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2213	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2214	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2216	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2218	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999
E2219	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each	6/1/2015	12/31/2999
E2221	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	6/1/2015	12/31/2999
E2222	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	6/1/2015	12/31/2999
E2228	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	1/1/2013	12/31/2999
E2230	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM	1/1/2013	12/31/2999
E2231	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2291	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Back, planar, for pediatric size wheelchair including fixed attaching hardware	1/1/2013	12/31/2999
E2292	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	1/1/2013	12/31/2999
E2293	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	1/1/2013	12/31/2999
E2294	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES	1/1/2013	12/31/2999
E2298	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type	4/1/2024	12/31/2999
E2301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Wheelchair accessory, power standing system, any type	1/1/2021	12/31/2999
E2310	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	1/1/2013	12/31/2999
E2311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	1/1/2013	12/31/2999
E2312	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL	1/1/2013	12/31/2999
E2313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER,	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2321	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	6/1/2015	12/31/2999
E2322	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	1/1/2013	12/31/2999
E2323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	1/1/2013	12/31/2999
E2324	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, chin cup for chin control interface	1/1/2013	12/31/2999
E2325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	1/1/2013	12/31/2999
E2326	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, breath tube kit for sip and puff interface	1/1/2013	12/31/2999
E2327	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2328	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	1/1/2013	12/31/2999
E2329	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	1/1/2013	12/31/2999
E2330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	1/1/2013	12/31/2999
E2331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	1/1/2013	12/31/2999
E2340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	1/1/2013	12/31/2999
E2341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	1/1/2013	12/31/2999
E2342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	1/1/2013	12/31/2999
E2343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	1/1/2013	12/31/2999
E2358	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	1/1/2013	12/31/2999
E2359	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	1/1/2013	12/31/2999
E2360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, 22 nf non-sealed lead acid battery, each	6/1/2015	12/31/2999
E2361	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat)	6/1/2015	12/31/2999
E2362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	6/1/2015	12/31/2999
E2363	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	6/1/2015	12/31/2999
E2364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, u-1 non-sealed lead acid battery, each	6/1/2015	12/31/2999
E2365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat)	6/1/2015	12/31/2999
E2366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	6/1/2015	12/31/2999
E2371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH	6/1/2015	12/31/2999
E2372	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	6/1/2015	12/31/2999
E2373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	6/1/2015	12/31/2999
E2374	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	6/1/2015	12/31/2999
E2375	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	6/1/2015	12/31/2999
E2376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2377	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	6/1/2015	12/31/2999
E2381	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2383	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2384	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2385	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2386	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2387	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2388	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2389	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2394	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2395	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	11/15/2020	12/31/2999
E2397	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	1/1/2013	12/31/2999
E2402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Negative pressure wound therapy electrical pump, stationary or portable	1/1/2013	12/31/2999
E2500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	1/1/2013	12/31/2999
E2502	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	1/1/2013	12/31/2999
E2504	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	1/1/2013	12/31/2999
E2506	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2508	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	1/1/2013	12/31/2999
E2510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	1/1/2013	12/31/2999
E2511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech generating software program, for personal computer or personal digital assistant	1/1/2013	12/31/2999
E2512	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Accessory for speech generating device, mounting system	1/1/2013	12/31/2999
E2513	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Accessory for speech generating device, electromyographic sensor	10/1/2024	12/31/2999
E2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Accessory for speech generating device, not otherwise classified	1/1/1950	12/31/2999
E2599	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Accessory for speech generating device, not otherwise classified	1/1/2013	12/31/2999
E2601	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999
E2602	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2603	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2604	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2605	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999
E2606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2607	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999
E2608	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	1/1/2013	12/31/2999
E2610	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR SEAT CUSHION, POWERED	9/1/2020	12/31/2999
E2611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2612	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2617	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2619	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH	11/15/2020	12/31/2999
E2620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	1/1/2013	12/31/2999
E2622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999
E2623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	1/1/2013	12/31/2999
E2625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	1/1/2013	12/31/2999
E2626	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	6/1/2015	12/31/2999
E2627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	6/1/2015	12/31/2999
E2628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	6/1/2015	12/31/2999
E2629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	6/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
E2630	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	6/1/2015	12/31/2999
E2631	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	6/1/2015	12/31/2999
E2632	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	6/1/2015	12/31/2999
E2633	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	6/1/2015	12/31/2999
E3000	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Speech volume modulation system, any type, including all components and accessories	5/15/2024	12/31/2999
E3200	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only	10/1/2024	12/31/2999
G0029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user	1/1/2022	12/31/2999
G0031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Palliative care services given to patient any time during the measurement period	1/1/2022	12/31/2999
G0032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between january 1 of the year prior to the measurement period and the index prescription start date (ipsd) for antipsychotics	1/1/2022	12/31/2999
G0033	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between january 1 of the year prior to the measurement period and the ipsd for benzodiazepines	1/1/2022	12/31/2999
G0034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients receiving palliative care during the measurement period	1/1/2022	12/31/2999
G0035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has any emergency department encounter during the performance period with place of service indicator 23	1/1/2022	12/31/2999
G0036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient or care partner decline assessment	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	On date of encounter, patient is not able to participate in assessment or screening, including non-verbal patients, delirious, severely aphasic, severely developmentally delayed, severe visual or hearing impairment and for those patients, no knowledgeable informant available	1/1/2022	12/31/2999
G0038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician determines patient does not require referral	1/1/2022	12/31/2999
G0039	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not referred, reason not otherwise specified	1/1/2022	12/31/2999
G0040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient already receiving physical/occupational/speech/recreational therapy during the measurement period	1/1/2022	12/31/2999
G0041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient and/or care partner decline referral	1/1/2022	12/31/2999
G0042	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Referral to physical, occupational, speech, or recreational therapy	1/1/2022	12/31/2999
G0043	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with mechanical prosthetic heart valve	1/1/2022	12/31/2999
G0044	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with moderate or severe mitral stenosis	1/1/2022	12/31/2999
G0045	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinical follow-up and mrs score assessed at 90 days following endovascular stroke intervention	1/1/2022	12/31/2999
G0046	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinical follow-up and mrs score not assessed at 90 days following endovascular stroke intervention	1/1/2022	12/31/2999
G0047	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pediatric patient with minor blunt head trauma and pecarn prediction criteria are not assessed	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0048	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who receive palliative care services any time during the intake period through the end of the measurement year	1/1/2022	12/31/2999
G0049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	With maintenance hemodialysis (in-center and home hd) for the complete reporting month	1/1/2022	12/31/2999
G0050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a catheter that have limited life expectancy	1/1/2022	12/31/2999
G0051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients under hospice care in the current reporting month	1/1/2022	12/31/2999
G0052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients on peritoneal dialysis for any portion of the reporting month	1/1/2022	12/31/2999
G0053	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advancing rheumatology patient care mips value pathways	1/1/2022	12/31/2999
G0054	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Coordinating stroke care to promote prevention and cultivate positive outcomes mips value pathways	1/1/2022	12/31/2999
G0055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advancing care for heart disease mips value pathways	1/1/2022	12/31/2999
G0057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Proposed adopting best practices and promoting patient safety within emergency medicine mips value pathways	1/1/2022	12/31/2999
G0058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Improving care for lower extremity joint repair mips value pathways	1/1/2022	12/31/2999
G0059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient safety and support of positive experiences with anesthesia mips value pathways	1/1/2022	12/31/2999
G0060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Allergy/immunology mips specialty set	1/1/2022	12/31/2999
G0061	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anesthesiology mips specialty set	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0062	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Audiology mips specialty set	1/1/2022	12/31/2999
G0063	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cardiology mips specialty set	1/1/2022	12/31/2999
G0064	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Certified nurse midwife mips specialty set	1/1/2022	12/31/2999
G0065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chiropractic medicine mips specialty set	1/1/2022	12/31/2999
G0066	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinical social work mips specialty set	1/1/2022	12/31/2999
G0067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dentistry mips specialty set	1/1/2022	12/31/2999
G0068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2019	12/31/2999
G0069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2019	12/31/2999
G0076	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Brief (20 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0077	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0078	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Moderate (45 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0079	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extensive (75 minutes) care management home visit for a new patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0081	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Brief (20 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0082	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0083	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Moderate (45 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0084	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0085	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extensive (75 minutes) care management home visit for an existing patient. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0086	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) care management home care plan oversight. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0087	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 minutes) care management home care plan oversight. for use only in a medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	1/1/2019	12/31/2999
G0088	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2021	12/31/2999
G0089	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2021	12/31/2999
G0090	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0138	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	4/1/2024	12/31/2999
G0151	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	1/1/2013	12/31/2999
G0152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	1/1/2013	12/31/2999
G0153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	1/1/2013	12/31/2999
G0156	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES	3/1/2021	12/31/2999
G0157	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	1/1/2013	12/31/2999
G0158	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE PHYSICAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	1/1/2013	12/31/2999
G0160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE OCCUPATIONAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	1/1/2013	12/31/2999
G0161	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE SPEECH-LANGUAGE PATHOLOGY MAINTENANCE PROGRAM, EACH 15 MINUTES	1/1/2013	12/31/2999
G0176	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physician or allowed practitioner certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians and allowed practitioners to affirm the initial implementation of the plan of care	1/1/2013	12/31/2999
G0235	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Pet imaging, any site, not otherwise specified	10/24/2019	12/31/2999
G0255	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve	2/15/2015	12/31/2999
G0260	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography	9/15/2020	12/31/2999
G0276	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	2/1/2024	12/31/2999
G0276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0277	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	1/1/2015	12/31/2999
G0281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous statsis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	2/15/2015	12/31/2999
G0282	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in g0281	2/15/2015	12/31/2999
G0293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day	1/1/2013	12/31/2999
G0294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day	1/1/2013	12/31/2999
G0295	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses	2/15/2015	12/31/2999
G0299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes	8/1/2019	12/31/2999
G0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes	8/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time (this code is used for medicaid billing purposes)	5/11/2022	12/31/2999
G0311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time (this code is used for medicaid billing purposes)	5/11/2022	12/31/2999
G0312	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time (this code is used for medicaid billing purposes)	5/11/2022	12/31/2999
G0313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time (this code is used for medicaid billing purposes)	5/11/2022	12/31/2999
G0314	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 16-30 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt)	5/11/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 5-15 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt)	5/11/2022	12/31/2999
G0316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (do not report g0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416). (do not report g0316 for any time unit less than 15 minutes)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99306, 99310 for nursing facility evaluation and management services). (do not report g0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (do not report g0317 for any time unit less than 15 minutes)	1/1/2023	12/31/2999
G0318	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99345, 99350 for home or residence evaluation and management services). (do not report g0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (do not report g0318 for any time unit less than 15 minutes)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0329	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care	2/15/2015	12/31/2999
G0330	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room	1/1/2023	12/31/2999
G0333	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); INITIAL 30-DAY SUPPLY AS A BENEFICIARY	1/1/2013	12/31/2999
G0341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	1/1/2013	12/31/2999
G0342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	1/1/2013	12/31/2999
G0343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	1/1/2013	12/31/2999
G0400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	1/1/2019	12/31/2999
G0416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0422	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION	9/1/2020	12/31/2999
G0423	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION	9/1/2020	12/31/2999
G0428	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	12/1/2020	12/31/2999
G0429	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.)	1/1/2013	12/31/2999
G0448	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INSERTION OR REPLACEMENT OF A PERMANENT PACING CARDIOVERTER-DEFIBRILLATOR SYSTEM WITH TRANSVENOUS LEAD(S), SINGLE OR DUAL CHAMBER WITH INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM, FOR LEFT VENTRICULAR PACING	1/1/2013	12/31/2999
G0455	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen	4/1/2016	12/31/2999
G0460	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0465	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	4/15/2022	12/31/2999
G0490	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Face-to-face home health nursing visit by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) in an area with a shortage of home health agencies. (Services limited to RN or LPN only).	10/1/2016	12/31/2999
G0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Skilled services of a registered nurse (rn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	1/1/2017	12/31/2999
G0494	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Skilled services of a licensed practical nurse (lpn) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0495	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Skilled services of a registered nurse (rn), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	1/1/2017	12/31/2999
G0496	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Skilled services of a licensed practical nurse (lpn), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	1/1/2017	12/31/2999
G0501	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)	1/1/2017	12/31/2999
G0516	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)	1/1/2018	12/31/2999
G0517	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	1/1/2018	12/31/2999
G0518	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0546	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review	1/1/2025	12/31/2999
G0547	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0548	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review	1/1/2025	12/31/2999
G0549	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review	1/1/2025	12/31/2999
G0550	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0551	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes	1/1/2025	12/31/2999
G0552	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	6/15/2025	12/31/2999
G0553	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	6/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0554	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	6/15/2025	12/31/2999
G0555	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0556	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0557	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0558	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advanced primary care management services for a patient that is a qualified medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G0562	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	1/1/2025	12/31/2999
G0563	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	1/1/2025	12/31/2999
G0571	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intraoperative nerve(s) cryoablation for post-surgical pain relief (list separately in addition to code for primary service)	1/1/2026	12/31/2999
G0913	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	IMPROVEMENT IN VISUAL FUNCTION ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	5/16/2016	12/31/2999
G0914	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT CARE SURVEY WAS NOT COMPLETED BY PATIENT	5/16/2016	12/31/2999
G0915	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	IMPROVEMENT IN VISUAL FUNCTION NOT ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	5/16/2016	12/31/2999
G0916	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SATISFACTION WITH CARE ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	5/16/2016	12/31/2999
G0917	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient care survey was not completed by patient	5/16/2016	12/31/2999
G1025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient-months where there are more than one medicare capitated payment (mcp) provider listed for the month	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G1026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The number of adult patient-months in the denominator who were on maintenance hemodialysis using a catheter continuously for three months or longer under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month	1/1/2022	12/31/2999
G1027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The number of adult patient-months in the denominator who were on maintenance hemodialysis under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month using a catheter continuously for less than three months	1/1/2022	12/31/2999
G2000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blinded administration of convulsive therapy procedure, either electroconvulsive therapy (ect, current covered gold standard) or magnetic seizure therapy (mst, non-covered experimental therapy), performed in an approved ide-based clinical trial, per treatment session	8/1/2018	12/31/2999
G2001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2006	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2008	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2009	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes	1/1/2019	12/31/2999
G2013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.	4/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	4/1/2019	12/31/2999
G2015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive (60 mins) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.)	4/1/2019	12/31/2999
G2020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the sip component of the pcf model (do not bill with chronic care management codes)	4/1/2021	12/31/2999
G2021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Health care practitioners rendering treatment in place (tip)	1/1/2020	12/31/2999
G2022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	A model participant (ambulance supplier/provider), the beneficiary refuses services covered under the model (transport to an alternate destination/treatment in place)	1/1/2020	12/31/2999
G2025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2081	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients age 66 and older in institutional special needs plans (snp) or residing in long-term care with a pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period	1/1/2020	12/31/2999
G2082	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation	8/1/2021	12/31/2999
G2083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation	8/1/2021	12/31/2999
G2090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2092	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy prescribed or currently being taken	1/1/2020	12/31/2999
G2093	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons)	1/1/2020	12/31/2999
G2094	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., patient declined, other patient reasons)	1/1/2020	12/31/2999
G2096	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy was not prescribed, reason not given	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2097	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Episodes where the patient had a competing diagnosis on or within three days after the episode date (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, chronic sinusitis, infection of the adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or uti)	1/1/2020	12/31/2999
G2098	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2099	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period	1/1/2020	12/31/2999
G2106	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2107	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receiving <=5 mg daily prednisone (or equivalent), or ra activity is worsening, or glucocorticoid use is for less than 6 months	1/1/2020	12/31/2999
G2113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receiving >5 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2118	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period	1/1/2020	12/31/2999
G2121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Depression, anxiety, apathy, and psychosis assessed	1/1/2020	12/31/2999
G2122	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Depression, anxiety, apathy, and psychosis not assessed	1/1/2020	12/31/2999
G2125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 81 years of age and older with at least one claim/encounter for frailty during the six months prior to the measurement period through december 31 of the measurement period	1/1/2020	12/31/2999
G2126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2127	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 ? 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2020	12/31/2999
G2128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed, intra-cranial bleed, blood disorders, idiopathic thrombocytopenic purpura (itp), gastric bypass or documentation of active anticoagulant use during the measurement period)	1/1/2020	12/31/2999
G2129	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Procedure-related bp's not taken during an outpatient visit. examples include same day surgery, ambulatory service center, g.i. lab, dialysis, infusion center, chemotherapy	1/1/2020	12/31/2999
G2136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2137	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated improvement of less than 5.0 points	1/1/2020	12/31/2999
G2138	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater	1/1/2020	12/31/2999
G2139	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated improvement of less than 5.0 points	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater	1/1/2020	12/31/2999
G2141	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated improvement of less than 5.0 points	1/1/2020	12/31/2999
G2142	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 30 points or greater	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2143	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of less than 30 points	1/1/2020	12/31/2999
G2144	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 ? 20 weeks) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 30 points or greater	1/1/2020	12/31/2999
G2145	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of less than 30 points	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2146	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater	1/1/2020	12/31/2999
G2147	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated improvement of less than 5.0 points	1/1/2020	12/31/2999
G2148	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multimodal pain management was used	1/1/2020	12/31/2999
G2149	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not using multimodal pain management (e.g., allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during pacu stay, other medical reason(s))	1/1/2020	12/31/2999
G2150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multimodal pain management was not used	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
G2152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the neck impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	1/1/2020	12/31/2999
G2167	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the neck impairment successfully calculated and the score was less than zero (< 0)	1/1/2020	12/31/2999
G2168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes	1/1/2020	12/31/2999
G2169	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	1/1/2020	12/31/2999
G2172	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	All inclusive payment for services related to highly coordinated and integrated opioid use disorder (oud) treatment services furnished for the demonstration project	4/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2173	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Uri episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease)	1/1/2021	12/31/2999
G2174	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Uri episodes where the patient is taking antibiotics (table 1) in the 30 days prior to the episode date	1/1/2021	12/31/2999
G2175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease)	1/1/2021	12/31/2999
G2176	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Outpatient, ed, or observation visits that result in an inpatient admission	1/1/2021	12/31/2999
G2177	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acute bronchitis/bronchiolitis episodes when the patient had a new or refill prescription of antibiotics (table 1) in the 30 days prior to the episode date	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2178	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia, alzheimer's, etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation	1/1/2021	12/31/2999
G2179	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician documented that patient had medical reason for not performing lower extremity neurological exam	1/1/2021	12/31/2999
G2180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician documented that patient was not an eligible candidate for evaluation of footwear as patient is bilateral lower extremity amputee	1/1/2021	12/31/2999
G2181	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented due to medical reason or patient refusal of height or weight measurement	1/1/2021	12/31/2999
G2182	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receiving first-time biologic and/or immune response modifier therapy	1/1/2021	12/31/2999
G2183	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation patient unable to communicate and informant not available	1/1/2021	12/31/2999
G2184	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient does not have a caregiver	1/1/2021	12/31/2999
G2185	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation caregiver is trained and certified in dementia care	1/1/2021	12/31/2999
G2186	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient /caregiver dyad has been referred to appropriate resources and connection to those resources is confirmed	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2187	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: head trauma	1/1/2021	12/31/2999
G2188	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: new or change in headache above 50 years of age	1/1/2021	12/31/2999
G2189	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: abnormal neurologic exam	1/1/2021	12/31/2999
G2190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: headache radiating to the neck	1/1/2021	12/31/2999
G2191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: positional headaches	1/1/2021	12/31/2999
G2192	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: temporal headaches in patients over 55 years of age	1/1/2021	12/31/2999
G2193	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: new onset headache in pre-school children or younger (<6 years of age)	1/1/2021	12/31/2999
G2194	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: new onset headache in pediatric patients with disabilities for which headache is a concern as inferred from behavior	1/1/2021	12/31/2999
G2195	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical indications for imaging of the head: occipital headache in children	1/1/2021	12/31/2999
G2196	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user	1/1/2021	12/31/2999
G2199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for unhealthy alcohol use using a systematic screening method	1/1/2021	12/31/2999
G2200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as an unhealthy alcohol user received brief counseling	1/1/2021	12/31/2999
G2202	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive brief counseling if identified as an unhealthy alcohol user	1/1/2021	12/31/2999
G2204	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients between 45 and 85 years of age who received a screening colonoscopy during the performance period	1/1/2021	12/31/2999
G2205	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with pregnancy during adjuvant treatment course	1/1/2021	12/31/2999
G2206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received adjuvant treatment course including both chemotherapy and her2-targeted therapy	1/1/2021	12/31/2999
G2207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Reason for not administering adjuvant treatment course including both chemotherapy and her2-targeted therapy (e.g. poor performance status (ecog 3-4; karnofsky <=50), cardiac contraindications, insufficient renal function, insufficient hepatic function, other active or secondary cancer diagnoses, other medical contraindications, patients who died during initial treatment course or transferred during or after initial treatment course)	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G2208	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive adjuvant treatment course including both chemotherapy and her2-targeted therapy	1/1/2021	12/31/2999
G2209	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2021	12/31/2999
G2210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the neck impairment not measured because the patient did not complete the neck fs prom at initial evaluation and/or near discharge, reason not given	1/1/2021	12/31/2999
G2250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G3002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using g3002, 30 minutes must be met or exceeded.)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G3003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for g3002. when using g3003, 15 minutes must be met or exceeded.)	1/1/2023	12/31/2999
G4000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dermatology mips specialty set	1/1/2022	12/31/2999
G4001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Diagnostic radiology mips specialty set	1/1/2022	12/31/2999
G4002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Electrophysiology cardiac specialist mips specialty set	1/1/2022	12/31/2999
G4003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency medicine mips specialty set	1/1/2022	12/31/2999
G4004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Endocrinology mips specialty set	1/1/2022	12/31/2999
G4005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Family medicine mips specialty set	1/1/2022	12/31/2999
G4006	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Gastro-enterology mips specialty set	1/1/2022	12/31/2999
G4007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	General surgery mips specialty set	1/1/2022	12/31/2999
G4008	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Geriatrics mips specialty set	1/1/2022	12/31/2999
G4009	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospitalists mips specialty set	1/1/2022	12/31/2999
G4010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Infectious disease mips specialty set	1/1/2022	12/31/2999
G4011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Internal medicine mips specialty set	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G4012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Interventional radiology mips specialty set	1/1/2022	12/31/2999
G4013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental/behavioral and psychiatry mips specialty set	1/1/2022	12/31/2999
G4014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nephrology mips specialty set	1/1/2022	12/31/2999
G4015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Neurology mips specialty set	1/1/2022	12/31/2999
G4016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Neurosurgical mips specialty set	1/1/2022	12/31/2999
G4017	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nutrition/dietician mips specialty set	1/1/2022	12/31/2999
G4018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Obstetrics/gynecology mips specialty set	1/1/2022	12/31/2999
G4019	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology/hematology mips specialty set	1/1/2022	12/31/2999
G4020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ophthalmology/optometry mips specialty set	1/1/2022	12/31/2999
G4021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic surgery mips specialty set	1/1/2022	12/31/2999
G4022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Otolaryngology mips specialty set	1/1/2022	12/31/2999
G4023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology mips specialty set	1/1/2022	12/31/2999
G4024	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pediatrics mips specialty set	1/1/2022	12/31/2999
G4025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physical medicine mips specialty set	1/1/2022	12/31/2999
G4026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physical therapy/occupational therapy mips specialty set	1/1/2022	12/31/2999
G4027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Plastic surgery mips specialty set	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G4028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Podiatry mips specialty set	1/1/2022	12/31/2999
G4029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Preventive medicine mips specialty set	1/1/2022	12/31/2999
G4030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pulmonology mips specialty set	1/1/2022	12/31/2999
G4031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Radiation oncology mips specialty set	1/1/2022	12/31/2999
G4032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rheumatology mips specialty set	1/1/2022	12/31/2999
G4033	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Skilled nursing facility mips specialty set	1/1/2022	12/31/2999
G4034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Speech language pathology mips specialty set	1/1/2022	12/31/2999
G4035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Thoracic surgery mips specialty set	1/1/2022	12/31/2999
G4036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Urgent care mips specialty set	1/1/2022	12/31/2999
G4037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Urology mips specialty set	1/1/2022	12/31/2999
G4038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vascular surgery mips specialty set	1/1/2022	12/31/2999
G8395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR	5/16/2016	12/31/2999
G8396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	5/16/2016	12/31/2999
G8397	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8399	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed	5/16/2016	12/31/2999
G8400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given	5/16/2016	12/31/2999
G8404	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	5/16/2016	12/31/2999
G8405	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	5/16/2016	12/31/2999
G8410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	5/16/2016	12/31/2999
G8415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FOOTWEAR EVALUATION WAS NOT PERFORMED	5/16/2016	12/31/2999
G8416	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR	5/16/2016	12/31/2999
G8417	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented above normal parameters and a follow-up plan is documented	5/16/2016	12/31/2999
G8418	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented below normal parameters and a follow-up plan is documented	5/16/2016	12/31/2999
G8419	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	5/16/2016	12/31/2999
G8420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented within normal parameters and no follow-up plan is required	5/16/2016	12/31/2999
G8421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented and no reason is given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8427	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	5/16/2016	12/31/2999
G8428	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given	5/16/2016	12/31/2999
G8430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status)	5/16/2016	12/31/2999
G8431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression is documented as being positive and a follow-up plan is documented	5/16/2016	12/31/2999
G8432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Depression screening not documented, reason not given	5/16/2016	12/31/2999
G8433	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression not completed, documented patient or medical reason	5/16/2016	12/31/2999
G8450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy prescribed	5/16/2016	12/31/2999
G8451	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8452	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy not prescribed	5/16/2016	12/31/2999
G8465	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	High or very high risk of recurrence of prostate cancer	5/16/2016	12/31/2999
G8473	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER	5/16/2016	12/31/2999
G8474	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons)	5/16/2016	12/31/2999
G8475	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given	5/16/2016	12/31/2999
G8476	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg	5/16/2016	12/31/2999
G8477	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg	5/16/2016	12/31/2999
G8478	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure measurement not performed or documented, reason not given	5/16/2016	12/31/2999
G8510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression is documented as negative, a follow-up plan is not required	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for depression documented as positive, follow-up plan not documented, reason not given	5/16/2016	12/31/2999
G8535	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter related to one of the following reasons: (1) patient refuses to participate in the screening and has reasonable decisional capacity for self-protection, or (2) patient is in an urgent or emergent situation where time is of the essence and to delay treatment to perform the screening would jeopardize the patient's health status	5/16/2016	12/31/2999
G8536	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No documentation of an elder maltreatment screen, reason not given	5/16/2016	12/31/2999
G8539	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment documented as positive using a standardized tool and a care plan based on identified deficiencies is documented within two days of the functional outcome assessment	5/16/2016	12/31/2999
G8540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment not documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter	5/16/2016	12/31/2999
G8541	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment using a standardized tool not documented, reason not given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8542	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required	5/16/2016	12/31/2999
G8543	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given	5/16/2016	12/31/2999
G8559	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	5/16/2016	12/31/2999
G8560	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	5/16/2016	12/31/2999
G8561	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE	5/16/2016	12/31/2999
G8562	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	5/16/2016	12/31/2999
G8563	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	5/16/2016	12/31/2999
G8564	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8565	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	5/16/2016	12/31/2999
G8566	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS MEASURE	5/16/2016	12/31/2999
G8567	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	5/16/2016	12/31/2999
G8568	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given	5/16/2016	12/31/2999
G8569	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged postoperative intubation (> 24 hrs) required	5/16/2016	12/31/2999
G8570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prolonged postoperative intubation (> 24 hrs) not required	5/16/2016	12/31/2999
G8575	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED DIALYSIS	5/16/2016	12/31/2999
G8576	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED	5/16/2016	12/31/2999
G8577	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8578	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason	5/16/2016	12/31/2999
G8598	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy used	5/16/2016	12/31/2999
G8599	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy not used, reason not given	5/16/2016	12/31/2999
G8600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well	5/16/2016	12/31/2999
G8601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention)	5/16/2016	12/31/2999
G8602	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given	5/16/2016	12/31/2999
G8633	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	5/16/2016	12/31/2999
G8635	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacologic therapy for osteoporosis was not prescribed, reason not given	5/16/2016	12/31/2999
G8647	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the knee impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8648	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the knee impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8650	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the knee impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999
G8651	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the hip impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999
G8652	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the hip impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8654	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the hip impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999
G8655	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the lower leg, foot or ankle impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999
G8656	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the lower leg, foot or ankle impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8658	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the lower leg, foot or ankle impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8659	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the low back impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999
G8660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the low back impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8661	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Risk-adjusted functional status change residual score for the low back impairment not measured because the patient did not complete the fs status survey near discharge, patient not appropriate	5/16/2016	12/31/2999
G8662	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the low back impairment not measured because the patient did not complete the low back fs prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999
G8663	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the shoulder impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999
G8664	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the shoulder impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8666	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the shoulder impairment not measured because the patient did not complete the shoulder fs prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8667	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the elbow, wrist or hand impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0)	5/16/2016	12/31/2999
G8668	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the elbow, wrist or hand impairment successfully calculated and the score was less than zero (< 0)	5/16/2016	12/31/2999
G8670	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Residual score for the elbow, wrist or hand impairment not measured because the patient did not complete the elbow/wrist/hand fs prom at initial evaluation and/or near discharge, reason not given	5/16/2016	12/31/2999
G8694	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current or prior left ventricular ejection fraction (lvef) < = 40% or documentation of moderate or severe lvsd	5/16/2016	12/31/2999
G8708	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not prescribed antibiotic	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8709	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Uri episodes when the patient had competing diagnoses on or three days after the episode date (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or uti, and acne)	5/16/2016	12/31/2999
G8710	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient prescribed antibiotic	5/16/2016	12/31/2999
G8711	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prescribed antibiotic on or within 3 days after the episode date	5/16/2016	12/31/2999
G8712	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ANTIBIOTIC NOT PRESCRIBED OR DISPENSED	5/16/2016	12/31/2999
G8721	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PT CATEGORY (PRIMARY TUMOR), PN CATEGORY (REGIONAL LYMPH NODES), AND HISTOLOGIC GRADE WERE DOCUMENTED IN PATHOLOGY REPORT	5/16/2016	12/31/2999
G8722	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not including the pt category, the pn category or the histologic grade in the pathology report (e.g., re-excision without residual tumor; non-carcinomasanal canal)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8723	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SPECIMEN SITE IS OTHER THAN ANATOMIC LOCATION OF PRIMARY TUMOR	5/16/2016	12/31/2999
G8724	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pt category, pn category and histologic grade were not documented in the pathology report, reason not given	5/16/2016	12/31/2999
G8733	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elder maltreatment screen documented as positive and a follow-up plan is documented	5/16/2016	12/31/2999
G8734	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elder maltreatment screen documented as negative, follow-up is not required	5/16/2016	12/31/2999
G8735	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given	5/16/2016	12/31/2999
G8749	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Absence of signs of melanoma (tenderness, jaundice, localized neurologic signs such as weakness, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma)	5/16/2016	12/31/2999
G8752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MOST RECENT SYSTOLIC BLOOD PRESSURE < 140MMHG	5/16/2016	12/31/2999
G8753	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140MMHG	5/16/2016	12/31/2999
G8754	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MOST RECENT DIASTOLIC BLOOD PRESSURE < 90MMHG	5/16/2016	12/31/2999
G8755	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90MMHG	5/16/2016	12/31/2999
G8756	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No documentation of blood pressure measurement, reason not given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8783	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Normal blood pressure reading documented, follow-up not required	5/16/2016	12/31/2999
G8785	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure reading not documented, reason not given	5/16/2016	12/31/2999
G8797	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION OF ESOPHAGUS	5/16/2016	12/31/2999
G8798	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION OF PROSTATE	5/16/2016	12/31/2999
G8806	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Performance of trans-abdominal or trans-vaginal ultrasound and pregnancy location documented	5/16/2016	12/31/2999
G8807	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (e.g., patient has a documented intrauterine pregnancy [iup])	5/16/2016	12/31/2999
G8808	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Trans-abdominal or trans-vaginal ultrasound not performed, reason not given	5/16/2016	12/31/2999
G8815	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented reason in the medical records for why the statin therapy was not prescribed (i.e., lower extremity bypass was for a patient with non-artherosclerotic disease)	5/16/2016	12/31/2999
G8816	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	STATIN MEDICATION PRESCRIBED AT DISCHARGE	5/16/2016	12/31/2999
G8817	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Statin therapy not prescribed at discharge, reason not given	5/16/2016	12/31/2999
G8826	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient discharged to home no later than post-operative day #2 following evar	5/16/2016	12/31/2999
G8833	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not discharged to home by post-operative day #2 following evar	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8834	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT DISCHARGED TO HOME NO LATER THAN POST-OPERATIVE DAY #2 FOLLOWING CEA	5/16/2016	12/31/2999
G8838	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not discharged to home by post-operative day #2 following cea	5/16/2016	12/31/2999
G8839	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SLEEP APNEA SYMPTOMS ASSESSED, INCLUDING PRESENCE OR ABSENCE OF SNORING AND DAYTIME SLEEPINESS	5/16/2016	12/31/2999
G8840	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) for not documenting an assessment of sleep symptoms (e.g., patient didn't have initial daytime sleepiness, patient visited between initial testing and initiation of therapy)	5/16/2016	12/31/2999
G8841	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sleep apnea symptoms not assessed, reason not given	5/16/2016	12/31/2999
G8842	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Apnea hypopnea index (ahi), respiratory disturbance index (rdi) or respiratory event index (rei) documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8843	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) for not measuring an apnea hypopnea index (ahi), a respiratory disturbance index (rdi), or a respiratory event index (rei) within 2 months after initial evaluation for suspected obstructive sleep apnea (e.g., medical, neurological, or psychiatric disease that prohibits successful completion of a sleep study, patients for whom a sleep study would present a bigger risk than benefit or would pose an undue burden, dementia, patients previously diagnosed with osa and severity assessed by another provider, patients who decline ahi/rdi/rei measurement, patients who had a financial reason for not completing testing, test was ordered but not completed, patients decline because their insurance (payer) does not cover the expense)	5/16/2016	12/31/2999
G8844	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Apnea hypopnea index (ahi), respiratory disturbance index (rdi), or respiratory event index (rei) not documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea, reason not given	5/16/2016	12/31/2999
G8845	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	POSITIVE AIRWAY PRESSURE THERAPY PRESCRIBED	5/16/2016	12/31/2999
G8846	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MODERATE OR SEVERE OBSTRUCTIVE SLEEP APNEA (APNEA HYPOPNEA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) OF 15 OR GREATER)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8849	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) for not prescribing positive airway pressure therapy (e. G. , patient unable to tolerate, alternative therapies use, patient declined, financial, insurance coverage)	5/16/2016	12/31/2999
G8850	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Positive airway pressure therapy not prescribed, reason not given	5/16/2016	12/31/2999
G8851	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adherence to therapy was assessed at least annually through an objective informatics system or through self-reporting (if objective reporting is not available, documented)	5/16/2016	12/31/2999
G8854	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) for not objectively reporting adherence to evidence-based therapy (e.g., patients who have been diagnosed with a terminal or advanced disease with an expected life span of less than 6 months, patients who decline therapy, patients who do not return for follow-up at least annually, patients unable to access/afford therapy, patient's insurance will not cover therapy)	5/16/2016	12/31/2999
G8855	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adherence to therapy was not assessed at least annually through an objective informatics system or through self-reporting (if objective reporting is not available), reason not given	5/16/2016	12/31/2999
G8856	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	REFERRAL TO A PHYSICIAN FOR AN OTOLOGIC EVALUATION PERFORMED	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8857	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION MEASURE (E.G., PATIENTS WHO ARE ALREADY UNDER THE CARE OF A PHYSICIAN FOR ACUTE OR CHRONIC DIZZINESS)	5/16/2016	12/31/2999
G8858	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Referral to a physician for an otologic evaluation not performed, reason not given	5/16/2016	12/31/2999
G8863	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not assessed for risk of bone loss, reason not given	5/16/2016	12/31/2999
G8864	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PNEUMOCOCCAL VACCINE ADMINISTERED OR PREVIOUSLY RECEIVED	5/16/2016	12/31/2999
G8865	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G., PATIENT ALLERGIC REACTION, POTENTIAL ADVERSE DRUG REACTION)	5/16/2016	12/31/2999
G8866	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DOCUMENTATION OF PATIENT REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G., PATIENT REFUSAL)	5/16/2016	12/31/2999
G8867	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pneumococcal vaccine not administered or previously received, reason not given	5/16/2016	12/31/2999
G8869	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has documented immunity to hepatitis b and initiating anti-tnf therapy	5/16/2016	12/31/2999
G8875	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CLINICIAN DIAGNOSED BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8876	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer properatively (e.g., lesion too close to skin, implant, chest wall, etc., lesion could not be adequately visualized for needle biopsy, patient condition prevents needle biopsy [weight, breast thickness, etc.], duct excision without imaging abnormality, prophylactic mastectomy, reduction mammoplasty, excisional biopsy performed by another physician)	5/16/2016	12/31/2999
G8877	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given	5/16/2016	12/31/2999
G8878	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	SENTINEL LYMPH NODE BIOPSY PROCEDURE PERFORMED	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8880	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of reason(s) sentinel lymph node biopsy not performed (e.g., reasons could include but not limited to; non-invasive cancer, incidental discovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reduction mammoplasty, pre-operative biopsy proven lymph node (ln) metastases, inflammatory carcinoma, stage 3 locally advanced cancer, recurrent invasive breast cancer, clinically node positive after neoadjuvant systemic therapy, patient refusal after informed consent, patient with significant age, comorbidities, or limited life expectancy and favorable tumor; adjuvant systemic therapy unlikely to change)	5/16/2016	12/31/2999
G8881	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	STAGE OF BREAST CANCER IS GREATER THAN T1N0M0 OR T2N0M0	5/16/2016	12/31/2999
G8882	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sentinel lymph node biopsy procedure not performed, reason not given	5/16/2016	12/31/2999
G8907	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented not to have experienced any of the following events: a burn prior to discharge, a fall within the facility, wrong site/side/patient/procedure/implant event, a hospital transfer or hospital admission upon discharge from the facility.	5/16/2016	12/31/2999
G8908	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented to have received a burn prior to discharge	5/16/2016	12/31/2999
G8909	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented not to have received a burn prior to discharge	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented to have experienced a fall within ASC	5/16/2016	12/31/2999
G8911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented not to have experienced a fall within ASC	5/16/2016	12/31/2999
G8912	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	5/16/2016	12/31/2999
G8913	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	5/16/2016	12/31/2999
G8914	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC	5/16/2016	12/31/2999
G8915	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC	5/16/2016	12/31/2999
G8916	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis, antibiotic initiated on time.	5/16/2016	12/31/2999
G8917	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis, antibiotic not initiated on time.	5/16/2016	12/31/2999
G8918	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient without preoperative order for IV antibiotic surgical site infection. (SSI) prophylaxis	5/16/2016	12/31/2999
G8923	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current or prior left ventricular ejection fraction (lvef) <= 40% or documentation of moderately or severely depressed left ventricular systolic function	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8924	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Spirometry results documented (fev1/fvc < 70%)	5/16/2016	12/31/2999
G8934	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current or prior left ventricular ejection fraction (lvef) <=40% or documentation of moderately or severely depressed left ventricular systolic function	5/16/2016	12/31/2999
G8935	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician prescribed angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy	5/16/2016	12/31/2999
G8936	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy (eg, allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (eg, patient declined, other patient reasons)	5/16/2016	12/31/2999
G8937	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician did not prescribe angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy, reason not given	5/16/2016	12/31/2999
G8942	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies is documented within two days of the functional outcome assessment	5/16/2016	12/31/2999
G8944	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ajcc melanoma cancer stage 0 through iic melanoma	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8946	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Minimally invasive biopsy method attempted but not diagnostic of breast cancer (e.g., high risk lesion of breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular hyperplasia, lobular carcinoma in situ, atypical columnar hyperplasica, flat epithelial atypia, radial scar, complex sclerosing lesion, papillary lesion, or any lesion with spindle cells)	5/16/2016	12/31/2999
G8950	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented	5/16/2016	12/31/2999
G8952	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given	5/16/2016	12/31/2999
G8955	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent assessment of adequacy of volume management documented	5/16/2016	12/31/2999
G8956	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receiving maintenance hemodialysis in an outpatient dialysis facility	5/16/2016	12/31/2999
G8958	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assessment of adequacy of volume management not documented, reason not given	5/16/2016	12/31/2999
G8961	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cardiac stress imaging test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G8962	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cardiac stress imaging test performed on patient for any reason including those who did not have low risk surgery or test that was performed more than 30 days preceding low risk surgery	5/16/2016	12/31/2999
G8967	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fda approved oral anticoagulant is prescribed	5/16/2016	12/31/2999
G8968	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing an fda-approved anticoagulant (e.g., present or planned atrial appendage occlusion or ligation or patient being currently enrolled in a clinical trial related to af/atrial flutter treatment)	5/16/2016	12/31/2999
G8969	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing an oral anticoagulant that is fda approved for the prevention of thromboembolism (e.g., patient preference for not receiving anticoagulation)	5/16/2016	12/31/2999
G8970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No risk factors or one moderate risk factor for thromboembolism	5/16/2016	12/31/2999
G9012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Other specified case management service not elsewhere classified	10/24/2019	12/31/2999
G9013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ESRD DEMO BASIC BUNDLE LEVEL I	5/16/2016	12/31/2999
G9014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ESRD DEMO EXPANDED BUNDLE INCLUDING VENOUS ACCESS AND RELATED SERVICES	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes) [demo project code only]	5/16/2016	12/31/2999
G9050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9053	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9054	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9055	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	10/24/2019	12/31/2999
G9055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9056	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project)	1/1/2013	12/31/2999
G9058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9061	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9062	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9063	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage i (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9064	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage ii (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9066	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9071	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9072	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9073	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9074	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9077	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9078	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9079	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9083	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9084	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9085	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9086	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9087	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9088	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9089	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9091	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9092	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9093	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9094	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9095	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9096	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9097	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9098	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9099	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9103	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9104	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9106	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9107	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9123	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9124	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, stage i (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9129	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; stage ii or higher (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project)	5/16/2016	12/31/2999
G9131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9132	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9133	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9134	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9137	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9138	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999
G9139	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48 HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS PREVENT TRANSFER; PAYMENT IS MADE ON EACH PERIOD UP TO 4 HOURS, AFTER THE FIRST 4 HOURS	5/16/2016	12/31/2999
G9147	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	12/1/2020	12/31/2999
G9148	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	National Committee for Quality Assurance - Level I medical home	5/16/2016	12/31/2999
G9149	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	National Committee for Quality Assurance - Level II medical home	5/16/2016	12/31/2999
G9150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	National Committee for Quality Assurance - Level III medical home	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multi-payer Advanced Primary Care Practice Demonstration State	5/16/2016	12/31/2999
G9152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multi-payer Advanced Primary Care Practice Demonstration Community	5/16/2016	12/31/2999
G9153	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Multi-payer Advanced Primary Care Practice Demonstration Physician	5/16/2016	12/31/2999
G9187	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bundled Payments for Care Improvement Initiative home visit for patient assessment performed by a qualified health care professional for individuals not considered homebound including, but not limited to, assessment of safety, falls, clinical status, fluid status, medication reconciliation/management, patient compliance with orders/plan of care, performance of activities of daily living, appropriateness of care setting. (For use only in the Medicare-approved Bundled Payments for Care Improvement Initiative.) May not be billed for a 30-day period covered by a transitional care management code	10/1/2013	12/31/2999
G9188	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy not prescribed, reason not given	1/1/2014	12/31/2999
G9189	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Beta-blocker therapy prescribed or currently being taken	1/1/2014	12/31/2999
G9190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons)	1/1/2014	12/31/2999
G9212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dsm-ivtm criteria for major depressive disorder documented at the initial evaluation	1/1/2014	12/31/2999
G9213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dsm-iv-tr criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified	1/1/2014	12/31/2999
G9223	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low cd4+ cell count below 500 cells/mm3 or a cd4 percentage below 15%	1/1/2014	12/31/2999
G9225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot exam was not performed, reason not given	1/1/2014	12/31/2999
G9226	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot examination performed (includes examination through visual inspection, sensory exam with 10-g monofilament plus testing any one of the following: vibration using 128-hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold, and pulse exam; report when all of the 3 components are completed)	1/1/2014	12/31/2999
G9227	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter	1/1/2014	12/31/2999
G9228	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chlamydia, gonorrhea, and syphilis not screened, reason not given	1/1/2014	12/31/2999
G9231	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of end stage renal disease (esrd), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period	1/1/2014	12/31/2999
G9242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of viral load equal to or greater than 200 copies/ml or viral load not performed	1/1/2014	12/31/2999
G9243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of viral load less than 200 copies/ml	1/1/2014	12/31/2999
G9246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not have two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart	1/1/2014	12/31/2999
G9247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart	1/1/2014	12/31/2999
G9254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient discharged to home later than post-operative day 2 following cea or cas	1/1/2014	12/31/2999
G9255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient discharged to home no later than post operative day 2 following cea or cas	1/1/2014	12/31/2999
G9273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure has a systolic value of < 140 and a diastolic value of < 90	1/1/2014	12/31/2999
G9274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure has a systolic value of =140 and a diastolic value of = 90 or systolic value < 140 and diastolic value = 90 or systolic value = 140 and diastolic value < 90	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9275	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that patient is a current non-tobacco user	1/1/2014	12/31/2999
G9276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that patient is a current tobacco user	1/1/2014	12/31/2999
G9277	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that the patient is on daily aspirin or anti-platelet or has documentation of a valid contraindication or exception to aspirin/anti-platelet; contraindications/exceptions include anti-coagulant use, allergy to aspirin or anti-platelets, history of gastrointestinal bleed and bleeding disorder; additionally, the following exceptions documented by the physician as a reason for not taking daily aspirin or anti-platelet are acceptable (use of non-steroidal anti-inflammatory agents, documented risk for drug interaction, uncontrolled hypertension defined as >180 systolic or >110 diastolic or gastroesophageal reflux)	1/1/2014	12/31/2999
G9278	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that the patient is not on daily aspirin or anti-platelet regimen	1/1/2014	12/31/2999
G9279	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pneumococcal screening performed and documentation of vaccination received prior to discharge	1/1/2014	12/31/2999
G9280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pneumococcal vaccination not administered prior to discharge, reason not specified	1/1/2014	12/31/2999
G9281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening performed and documentation that vaccination not indicated/patient refusal	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g., biopsy taken for other purposes in a patient with a history of non-small cell lung cancer or other documented medical reasons)	1/1/2014	12/31/2999
G9283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as nsclc-nos with an explanation	1/1/2014	12/31/2999
G9284	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as nsclc-nos with an explanation	1/1/2014	12/31/2999
G9285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic location of lung or is not classified as non small cell lung cancer	1/1/2014	12/31/2999
G9286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Antibiotic regimen prescribed within10 days after onset of symptoms	1/1/2014	12/31/2999
G9287	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Antibiotic regimen not prescribed within 10 days after onset of symptoms	1/1/2014	12/31/2999
G9288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g., a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9289	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as nsclc-nos with an explanation	1/1/2014	12/31/2999
G9290	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as nsclc-nos with an explanation	1/1/2014	12/31/2999
G9291	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic location of lung, is not classified as non small cell lung cancer or classified as nsclc-nos	1/1/2014	12/31/2999
G9292	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not reporting pt category and a statement on thickness and ulceration and for pt1, mitotic rate (e.g., negative skin biopsies in a patient with a history of melanoma or other documented medical reasons)	1/1/2014	12/31/2999
G9293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report does not include the pt category and a statement on thickness and ulceration and for pt1, mitotic rate	1/1/2014	12/31/2999
G9294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report includes the pt category and a statement on thickness and ulceration and for pt1, mitotic rate	1/1/2014	12/31/2999
G9295	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic cutaneous location	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9296	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with documented shared decision-making including discussion of conservative (non-surgical) therapy (e.g., nsaids, analgesics, weight loss, exercise, injections) prior to the procedure	1/1/2014	12/31/2999
G9297	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Shared decision-making including discussion of conservative (non-surgical) therapy (e.g., nsaids, analgesics, weight loss, exercise, injections) prior to the procedure, not documented, reason not given	1/1/2014	12/31/2999
G9298	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of dvt, pe, mi, arrhythmia and stroke)	1/1/2014	12/31/2999
G9299	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are not evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g., history of dvt, pe, mi, arrhythmia and stroke, reason not given)	1/1/2014	12/31/2999
G9305	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intervention for presence of leak of endoluminal contents through an anastomosis not required	1/1/2014	12/31/2999
G9306	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intervention for presence of leak of endoluminal contents through an anastomosis required	1/1/2014	12/31/2999
G9307	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9308	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unplanned return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure	1/1/2014	12/31/2999
G9309	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No unplanned hospital readmission within 30 days of principal procedure	1/1/2014	12/31/2999
G9310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Unplanned hospital readmission within 30 days of principal procedure	1/1/2014	12/31/2999
G9311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No surgical site infection	1/1/2014	12/31/2999
G9312	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical site infection	1/1/2014	12/31/2999
G9313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis for documented reason	1/1/2014	12/31/2999
G9314	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis, reason not given	1/1/2014	12/31/2999
G9315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis	1/1/2014	12/31/2999
G9316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed	1/1/2014	12/31/2999
G9318	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Imaging study named according to standardized nomenclature	1/1/2014	12/31/2999
G9319	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Imaging study not named according to standardized nomenclature, reason not given	1/1/2014	12/31/2999
G9321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Count of previous ct (any type of ct) and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies documented in the 12-month period prior to the current study	1/1/2014	12/31/2999
G9322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Count of previous ct and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies not documented in the 12-month period prior to the current study, reason not given	1/1/2014	12/31/2999
G9341	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Search conducted for prior patient ct studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure, authorized, media-free, shared archive prior to an imaging study being performed	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Search not conducted prior to an imaging study being performed for prior patient ct studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure, authorized, media-free, shared archive, reason not given	1/1/2014	12/31/2999
G9344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Due to system reasons search not conducted for dicom format images for prior patient ct imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., non-affiliated external healthcare facilities or entities does not have archival abilities through a shared archival system)	1/1/2014	12/31/2999
G9345	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Follow-up recommendations documented according to recommended guidelines for incidentally detected pulmonary nodules (e.g., follow-up ct imaging studies needed or that no follow-up is needed) based at a minimum on nodule size and patient risk factors	1/1/2014	12/31/2999
G9347	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Follow-up recommendations not documented according to recommended guidelines for incidentally detected pulmonary nodules, reason not given	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	More than one ct scan of the paranasal sinuses ordered or received within 90 days after diagnosis	1/1/2014	12/31/2999
G9352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	More than one ct scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis, reason not given	1/1/2014	12/31/2999
G9353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	More than one ct scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (eg, patients with complications, second ct obtained prior to surgery, other medical reasons)	1/1/2014	12/31/2999
G9354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	One ct scan or no ct scan of the paranasal sinuses ordered within 90 days after the date of diagnosis	1/1/2014	12/31/2999
G9355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elective delivery (without medical indication) by cesarean birth or induction of labor not performed (<39 weeks of gestation)	1/1/2014	12/31/2999
G9356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elective delivery (without medical indication) by cesarean birth or induction of labor performed (<39 weeks of gestation)	1/1/2014	12/31/2999
G9357	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Post-partum screenings, evaluations and education performed	1/1/2014	12/31/2999
G9358	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Post-partum screenings, evaluations and education not performed	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9361	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medical indication for delivery by cesarean birth or induction of labor (<39 weeks of gestation) [documentation of reason(s) for elective delivery (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes (premature or prolonged), maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, late pregnancy, prior uterine surgery, or participation in clinical trial)]	5/16/2016	12/31/2999
G9364	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sinusitis caused by, or presumed to be caused by, bacterial infection	5/16/2016	12/31/2999
G9367	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class	5/16/2016	12/31/2999
G9368	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class not ordered	5/16/2016	12/31/2999
G9380	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient offered assistance with end of life issues or existing end of life plan was reviewed or updated during the measurement period	5/16/2016	12/31/2999
G9382	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not offered assistance with end of life issues or existing end of life plan was not reviewed or updated during the measurement period	5/16/2016	12/31/2999
G9383	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received screening for hcv infection within the 12 month reporting period	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9384	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not receiving annual screening for hcv infection (e.g., decompensated cirrhosis indicating advanced disease [i.e., ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)	5/16/2016	12/31/2999
G9385	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not receiving annual screening for hcv infection (e.g., patient declined, other patient reasons)	5/16/2016	12/31/2999
G9386	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening for hcv infection not received within the 12 month reporting period, reason not given	5/16/2016	12/31/2999
G9393	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with an initial phq-9 score greater than nine who achieves remission at twelve months as demonstrated by a twelve month (+/- 30 days) phq-9 score of less than five	5/16/2016	12/31/2999
G9394	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient who had a diagnosis of bipolar disorder or personality disorder, death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement or assessment period	5/16/2016	12/31/2999
G9395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with an initial phq-9 score greater than nine who did not achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) phq-9 score greater than or equal to five	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9396	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with an initial phq-9 score greater than nine who was not assessed for remission at twelve months (+/- 30 days)	5/16/2016	12/31/2999
G9408	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days	5/16/2016	12/31/2999
G9409	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days	5/16/2016	12/31/2999
G9410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision	5/16/2016	12/31/2999
G9411	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision	5/16/2016	12/31/2999
G9412	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision	5/16/2016	12/31/2999
G9413	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision	5/16/2016	12/31/2999
G9414	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had one dose of meningococcal vaccine (serogroups a, c, w, y or a, c, w, y, b) on or between the patient's 10th and 13th birthdays	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9415	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not have one dose of meningococcal vaccine (serogroups a, c, w, y or a, c, w, y, b), on or between the patient's 10th and 13th birthdays	5/16/2016	12/31/2999
G9416	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had one tetanus, diphtheria toxoids and acellular pertussis vaccine (tdap) on or between the patient's 10th and 13th birthdays	5/16/2016	12/31/2999
G9417	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not have one tetanus, diphtheria toxoids and acellular pertussis vaccine (tdap) on or between the patient's 10th and 13th birthdays	5/16/2016	12/31/2999
G9418	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Primary non-small cell lung cancer lung biopsy and cytology specimen report documents classification into specific histologic type following iaslc guidance or classified as nsclc-nos with an explanation	5/16/2016	12/31/2999
G9419	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not including the histological type or nsclc-nos classification with an explanation (e.g. specimen insufficient or non-diagnostic, specimen does not contain cancer, or other documented medical reasons)	5/16/2016	12/31/2999
G9420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9421	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Primary non-small cell lung cancer lung biopsy and cytology specimen report does not document classification into specific histologic type or histologic type does not follow iaslc guidance or is classified as nsclc-nos but without an explanation	5/16/2016	12/31/2999
G9422	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Primary lung carcinoma resection report documents pt category, pn category and for non-small cell lung cancer, histologic type (e.g., squamous cell carcinoma, adenocarcinoma and not nsclc-nos)	5/16/2016	12/31/2999
G9423	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not reporting the histological type or nsclc-nos classification with an explanation (e.g., a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)	5/16/2016	12/31/2999
G9424	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic location of lung, is not classified as non-small cell lung cancer or classified as nsclc-nos	5/16/2016	12/31/2999
G9425	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Primary lung carcinoma resection report does not document pt category, pn category and for non-small cell lung cancer, histologic type (e.g., squamous cell carcinoma, adenocarcinoma)	5/16/2016	12/31/2999
G9426	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Improvement in median time from ed arrival to initial ed oral or parenteral pain medication administration performed for ed admitted patients	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9427	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Improvement in median time from ed arrival to initial ed oral or parenteral pain medication administration not performed for ed admitted patients	5/16/2016	12/31/2999
G9428	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report includes the pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors	5/16/2016	12/31/2999
G9429	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not including pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors (e.g., negative skin biopsies, insufficient tissue, or other documented medical reasons)	5/16/2016	12/31/2999
G9430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specimen site other than anatomic cutaneous location	5/16/2016	12/31/2999
G9431	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report does not include the pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors	5/16/2016	12/31/2999
G9432	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Asthma well-controlled based on the act, c-act, acq, or ataq score and results documented	5/16/2016	12/31/2999
G9434	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Asthma not well-controlled based on the act, c-act, acq, or ataq score, or specified asthma control tool not used, reason not given	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9455	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient underwent abdominal imaging with ultrasound, contrast enhanced ct or contrast mri for hcc	5/16/2016	12/31/2999
G9456	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical or patient reason(s) for not ordering or performing screening for hcc. medical reason: comorbid medical conditions with expected survival < 5 years, hepatic decompensation and not a candidate for liver transplantation, or other medical reasons; patient reasons: patient declined or other patient reasons (e.g., cost of tests, time related to accessing testing equipment)	5/16/2016	12/31/2999
G9457	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not undergo abdominal imaging and did not have a documented reason for not undergoing abdominal imaging in the submission period	5/16/2016	12/31/2999
G9468	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600mg prednisone or greater for all fills	5/16/2016	12/31/2999
G9470	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600mg prednisone or greater for all fills	5/16/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9471	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Within the past 2 years, central dual-energy x-ray absorptiometry (dxa) not ordered or documented	5/16/2016	12/31/2999
G9473	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by chaplain in the hospice setting, each 15 minutes	1/1/2021	12/31/2999
G9474	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by dietary counselor in the hospice setting, each 15 minutes	1/1/2021	12/31/2999
G9475	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by other counselor in the hospice setting, each 15 minutes	1/1/2021	12/31/2999
G9476	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by volunteer in the hospice setting, each 15 minutes	1/1/2016	12/31/2999
G9477	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by care coordinator in the hospice setting, each 15 minutes	1/1/2016	12/31/2999
G9478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services performed by other qualified therapist in the hospice setting, each 15 minutes	1/1/2021	12/31/2999
G9479	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by qualified pharmacist in the hospice setting, each 15 minutes	1/1/2016	12/31/2999
G9480	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Admission to medicare care choice model program (mccm)	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9481	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9482	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9483	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate severity. typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9484	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9485	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved cms innovation center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9486	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project, which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9487	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project, which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9488	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project, which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9489	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved cms innovation center demonstration project, which requires at least 2 of the following 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	4/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9490	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CMS innovation center models, home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. (for use only in medicare-approved cms innovation center models); may not be billed for a 30 day period covered by a transitional care management code	4/1/2016	12/31/2999
G9497	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery	1/1/2016	12/31/2999
G9498	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Antibiotic regimen prescribed	1/1/2016	12/31/2999
G9500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Radiation exposure indices documented in final report for procedure using fluoroscopy	1/1/2016	12/31/2999
G9501	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Radiation exposure indices not documented in final report for procedure using fluoroscopy, reason not given	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9502	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason for not performing foot exam (i.e., patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period)	1/1/2016	12/31/2999
G9504	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented reason for not assessing hepatitis b virus (hbv) status (e.g., patient not initiating anti-tnf therapy, patient declined) prior to initiating anti-tnf therapy	1/1/2016	12/31/2999
G9505	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Antibiotic regimen prescribed within 10 days after onset of symptoms for documented medical reason	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9507	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that the patient is on a statin medication or has documentation of a valid contraindication or exception to statin medications; contraindications/exceptions that can be defined by diagnosis codes include pregnancy during the measurement period, active liver disease, rhabdomyolysis, end stage renal disease on dialysis and heart failure; provider documented contraindications/exceptions include breastfeeding during the measurement period, woman of child-bearing age not actively taking birth control, allergy to statin, drug interaction (hiv protease inhibitors, nefazodone, cyclosporine, gemfibrozil, and danazol) and intolerance (with supporting documentation of trying a statin at least once within the last 5 years or diagnosis codes for myostitis or toxic myopathy related to drugs)	1/1/2016	12/31/2999
G9508	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that the patient is not on a statin medication	1/1/2016	12/31/2999
G9509	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adult patients 18 years of age or older with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adult patients 18 years of age or older with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq- 9 or phq-9m score was not assessed or is greater than or equal to 5	1/1/2016	12/31/2999
G9511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Index event date phq-9 or phq-9m score greater than 9 documented during the twelve month denominator identification period	1/1/2016	12/31/2999
G9512	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Individual had a pdc of 0.8 or greater	1/1/2016	12/31/2999
G9513	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Individual did not have a pdc of 0.8 or greater	1/1/2016	12/31/2999
G9514	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient required a return to the operating room within 90 days of surgery	1/1/2016	12/31/2999
G9515	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not require a return to the operating room within 90 days of surgery	1/1/2016	12/31/2999
G9516	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of surgery	1/1/2016	12/31/2999
G9517	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given	1/1/2016	12/31/2999
G9518	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of active injection drug use	1/1/2016	12/31/2999
G9519	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient achieves final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient does not achieve final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery	1/1/2016	12/31/2999
G9521	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months	1/1/2016	12/31/2999
G9522	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months or patient not screened, reason not given	1/1/2016	12/31/2999
G9529	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with minor blunt head trauma had an appropriate indication(s) for a head ct	1/1/2016	12/31/2999
G9530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider	1/1/2016	12/31/2999
G9531	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has documentation of ventricular shunt, brain tumor, multisystem trauma, or is currently taking an antiplatelet medication including: abciximab, anagrelide, cangrelor, cilostazol, clopidogrel, dipyridamole, eptifibatide, prasugrel, ticlopidine, ticagrelor, tirofiban, or vorapaxar	1/1/2016	12/31/2999
G9533	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with minor blunt head trauma did not have an appropriate indication(s) for a head ct	1/1/2016	12/31/2999
G9537	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Imaging needed as part of a clinical trial; or other clinician ordered the study	1/1/2016	12/31/2999
G9539	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intent for potential removal at time of placement	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient alive 3 months post procedure	1/1/2016	12/31/2999
G9541	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Filter removed within 3 months of placement	1/1/2016	12/31/2999
G9542	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented re-assessment for the appropriateness of filter removal within 3 months of placement	1/1/2016	12/31/2999
G9543	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement	1/1/2016	12/31/2999
G9544	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients that do not have the filter removed, documented re-assessment for the appropriateness of filter removal, or documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement	1/1/2016	12/31/2999
G9547	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cystic renal lesion that is simple appearing (bosniak i or ii) , or adrenal lesion less than or equal to 1.0 cm or adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced ct or washout protocol ct, or mri with in- and opposed-phase sequences or other equivalent institutional imaging protocols	1/1/2016	12/31/2999
G9548	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for imaging studies stating no follow-up imaging is recommended	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9549	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has lymphadenopathy, signs of metastasis or an active diagnosis or history of cancer, and other medical reason(s))	1/1/2016	12/31/2999
G9550	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for imaging studies with follow-up imaging recommended, or final reports that do not include a specific recommendation of no follow-up	1/1/2016	12/31/2999
G9551	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for imaging studies without an incidentally found lesion noted	1/1/2016	12/31/2999
G9552	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incidental thyroid nodule < 1.0 cm noted in report	1/1/2016	12/31/2999
G9553	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prior thyroid disease diagnosis	1/1/2016	12/31/2999
G9554	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for ct, cta, mri or mra of the chest or neck with follow-up imaging recommended	1/1/2016	12/31/2999
G9555	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for recommending follow up imaging (e.g., patient has multiple endocrine neoplasia, patient has cervical lymphadenopathy, other medical reason(s))	1/1/2016	12/31/2999
G9556	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for ct, cta, mri or mra of the chest or neck with follow-up imaging not recommended	1/1/2016	12/31/2999
G9557	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports for ct, cta, mri or mra studies of the chest or neck without an incidentally found thyroid nodule < 1.0 cm noted or no nodule found	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9580	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Door to puncture time of 90 minutes or less	1/1/2016	12/31/2999
G9582	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Door to puncture time of greater than 90 minutes, no reason given	1/1/2016	12/31/2999
G9593	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pediatric patient with minor blunt head trauma classified as low risk according to the pecarn prediction rules	1/1/2016	12/31/2999
G9594	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider	1/1/2016	12/31/2999
G9595	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has documentation of ventricular shunt, brain tumor, or coagulopathy	1/1/2016	12/31/2999
G9597	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pediatric patient with minor blunt head trauma not classified as low risk according to the pecarn prediction rules	1/1/2016	12/31/2999
G9598	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted ct or minor diameter on axial formatted ct	1/1/2016	12/31/2999
G9599	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted ct or minor diameter on axial formatted ct	1/1/2016	12/31/2999
G9603	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient survey score improved from baseline following treatment	1/1/2016	12/31/2999
G9605	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient survey score did not improve from baseline following treatment	1/1/2016	12/31/2999
G9606	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraoperative cystoscopy performed to evaluate for lower tract injury	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9607	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented medical reasons for not performing intraoperative cystoscopy (e.g., urethral pathology precluding cystoscopy, any patient who has a congenital or acquired absence of the urethra) or in the case of patient death	1/1/2016	12/31/2999
G9608	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraoperative cystoscopy not performed to evaluate for lower tract injury	1/1/2016	12/31/2999
G9609	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of an order for anti-platelet agents	1/1/2016	12/31/2999
G9610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) in the patient's record for not ordering anti-platelet agents	1/1/2016	12/31/2999
G9611	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Order for anti-platelet agents was not documented in the patient's record, reason not given	1/1/2016	12/31/2999
G9621	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling	1/1/2016	12/31/2999
G9622	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	1/1/2016	12/31/2999
G9624	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user	1/1/2016	12/31/2999
G9625	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient sustained bladder injury at the time of surgery or discovered subsequently up to 30 days post-surgery	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9626	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented medical reason for not reporting bladder injury (e.g., gynecologic or other pelvic malignancy documented, concurrent surgery involving bladder pathology, injury that occurs during a urinary incontinence procedure, patient death from non-medical causes not related to surgery, patient died during procedure without evidence of bladder injury)	1/1/2016	12/31/2999
G9627	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not sustain bladder injury at the time of surgery nor discovered subsequently up to 30 days post-surgery	1/1/2016	12/31/2999
G9628	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient sustained bowel injury at the time of surgery or discovered subsequently up to 30 days post-surgery	1/1/2016	12/31/2999
G9629	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented medical reasons for not reporting bowel injury (e.g., gynecologic or other pelvic malignancy documented, planned (e.g., not due to an unexpected bowel injury) resection and/or re-anastomosis of bowel, or patient death from non-medical causes not related to surgery, patient died during procedure without evidence of bowel injury)	1/1/2016	12/31/2999
G9630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not sustain a bowel injury at the time of surgery nor discovered subsequently up to 30 days post-surgery	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9637	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports without documentation of one or more dose reduction techniques (e.g., automated exposure control, adjustment of the ma and/or kv according to patient size, use of iterative reconstruction technique)	1/1/2016	12/31/2999
G9638	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Final reports without documentation of one or more dose reduction techniques (e.g., automated exposure control, adjustment of the ma and/or kv according to patient size, use of iterative reconstruction technique)	1/1/2016	12/31/2999
G9642	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current smoker (e.g., cigarette, cigar, pipe, e-cigarette or marijuana)	1/1/2016	12/31/2999
G9643	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elective surgery	1/1/2016	12/31/2999
G9644	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure	1/1/2016	12/31/2999
G9645	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure	1/1/2016	12/31/2999
G9646	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with 90 day mrs score of 0 to 2	1/1/2016	12/31/2999
G9648	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with 90 day mrs score greater than 2	1/1/2016	12/31/2999
G9649	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psoriasis assessment tool documented meeting any one of the specified benchmarks (e.g., (pga; 5-point or 6-point scale), body surface area (bsa), psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi))	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9651	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Psoriasis assessment tool documented not meeting any one of the specified benchmarks (e.g., (pga; 5-point or 6-point scale), body surface area (bsa), psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi)) or psoriasis assessment tool not documented	1/1/2016	12/31/2999
G9654	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Monitored anesthesia care (mac)	1/1/2016	12/31/2999
G9655	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	A transfer of care protocol or handoff tool/checklist that includes the required key handoff elements is used	1/1/2016	12/31/2999
G9656	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient transferred directly from anesthetizing location to pacu or other non-icu location	1/1/2016	12/31/2999
G9658	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	A transfer of care protocol or handoff tool/checklist that includes the required key handoff elements is not used	1/1/2016	12/31/2999
G9659	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients greater than or equal to 86 years of age who underwent a screening colonoscopy and did not have a history of colorectal cancer or other valid medical reason for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, familial adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for a colonoscopy performed on a patient greater than or equal to 86 years of age (e.g., iron deficiency anemia, lower gastrointestinal bleeding, familial history of adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits)	1/1/2016	12/31/2999
G9661	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients greater than or equal to 86 years of age who received a colonoscopy for an assessment of signs/symptoms of gi tract illness, and/or because the patient meets high risk criteria, and/or to follow-up on previously diagnosed advanced lesions	1/1/2016	12/31/2999
G9662	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Previously diagnosed or have a diagnosis of clinical ascvd, including ascvd procedure	1/1/2016	12/31/2999
G9663	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Any ldl-c laboratory result >= 190 mg/dl	1/1/2016	12/31/2999
G9664	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are currently statin therapy users or received an order (prescription) for statin therapy	1/1/2016	12/31/2999
G9665	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are not currently statin therapy users or did not receive an order (prescription) for statin therapy	1/1/2016	12/31/2999
G9674	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with clinical ascvd diagnosis	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9675	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who have ever had a fasting or direct laboratory result of ldl-c = 190 mg/dl	1/1/2016	12/31/2999
G9676	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients aged 40 to 75 years at the beginning of the measurement period with type 1 or type 2 diabetes and with an ldl-c result of 70-189 mg/dl recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period	1/1/2016	12/31/2999
G9679	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Onsite acute care treatment of a nursing facility resident with pneumonia. May only be billed oncper day per beneficiary.	10/1/2016	12/31/2999
G9680	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Onsite acute care treatment of a nursing facility resident with CHF. May only be billed once per day per beneficiary.	10/1/2016	12/31/2999
G9681	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Onsite acute care treatment of a resident with COPD or asthma. May only be billed once per day per beneficiary.	10/1/2016	12/31/2999
G9682	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Onsite acute care treatment a nursing facility resident with a skin infection. May only be billed once per day per beneficiary	10/1/2016	12/31/2999
G9683	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder. (may only be billed once per day per beneficiary). this service is for a demonstration project	10/1/2016	12/31/2999
G9684	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Onsite acute care treatment of a nursing facility resident for a UTI. May only be billed once per day per beneficiary.	10/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9685	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. this service is for a demonstration project	10/1/2016	12/31/2999
G9687	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2017	12/31/2999
G9688	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients using hospice services any time during the measurement period	1/1/2017	12/31/2999
G9689	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient admitted for performance of elective carotid intervention	1/1/2017	12/31/2999
G9690	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receiving hospice services any time during the measurement period	1/1/2017	12/31/2999
G9691	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had hospice services any time during the measurement period	1/1/2017	12/31/2999
G9692	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services received by patient any time during the measurement period	1/1/2017	12/31/2999
G9693	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient use of hospice services any time during the measurement period	1/1/2017	12/31/2999
G9694	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services utilized by patient any time during the measurement period	1/1/2017	12/31/2999
G9695	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Long-acting inhaled bronchodilator prescribed	1/1/2017	12/31/2999
G9696	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator (e.g., patient intolerance or history of side effects)	1/1/2017	12/31/2999
G9698	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of system reason(s) for not prescribing a long-acting inhaled bronchodilator (e.g., cost of treatment or lack of insurance)	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9699	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Long-acting inhaled bronchodilator not prescribed, reason not otherwise specified	1/1/2017	12/31/2999
G9700	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9703	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Episodes where the patient is taking antibiotics (table 1) in the 30 days prior to the episode date	1/1/2017	12/31/2999
G9704	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ajcc breast cancer stage i: t1 mic or t1a documented	1/1/2017	12/31/2999
G9705	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ajcc breast cancer stage i: t1b (tumor > 0.5 cm but <= 1 cm in greatest dimension) documented	1/1/2017	12/31/2999
G9706	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Low (or very low) risk of recurrence, prostate cancer	1/1/2017	12/31/2999
G9708	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy	1/1/2017	12/31/2999
G9709	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services used by patient any time during the measurement period	1/1/2017	12/31/2999
G9710	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was provided hospice services any time during the measurement period	1/1/2017	12/31/2999
G9711	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis or past history of total colectomy or colorectal cancer	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9712	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for prescribing or dispensing antibiotic (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/uti, acne, hiv disease/asymptomatic hiv, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis	1/1/2017	12/31/2999
G9713	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9714	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is using hospice services any time during the measurement period	1/1/2017	12/31/2999
G9716	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9717	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating the patient has had a diagnosis of bipolar disorder	1/1/2017	12/31/2999
G9719	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair	1/1/2017	12/31/2999
G9720	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services for patient occurred any time during the measurement period	1/1/2017	12/31/2999
G9721	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair	1/1/2017	12/31/2999
G9722	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented history of renal failure or baseline serum creatinine >= 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation the cr has been or is 4.0 or higher	1/1/2017	12/31/2999
G9723	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services for patient received any time during the measurement period	1/1/2017	12/31/2999
G9724	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had documentation of use of anticoagulant medications overlapping the measurement year	1/1/2017	12/31/2999
G9726	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999
G9727	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9728	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999
G9729	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999
G9730	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999
G9731	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999
G9732	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999
G9733	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the low back fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999
G9734	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999
G9735	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the shoulder fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999
G9736	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient refused to participate	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9737	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the elbow/wrist/hand fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	1/1/2017	12/31/2999
G9740	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services given to patient any time during the measurement period	1/1/2017	12/31/2999
G9741	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9744	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not eligible due to active diagnosis of hypertension	1/1/2017	12/31/2999
G9745	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented reason for not screening or recommending a follow-up for high blood pressure	1/1/2017	12/31/2999
G9746	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of af (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)	1/1/2017	12/31/2999
G9752	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency surgery	1/1/2017	12/31/2999
G9753	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason for not conducting a search for dicom format images for prior patient ct imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., trauma, acute myocardial infarction, stroke, aortic aneurysm where time is of the essence)	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9754	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	A finding of an incidental pulmonary nodule	1/1/2017	12/31/2999
G9755	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not including a recommended interval and modality for follow-up or for no follow-up, and source of recommendations (e.g., patients with unexplained fever, immunocompromised patients who are at risk for infection)	1/1/2017	12/31/2999
G9756	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical procedures that included the use of silicone oil	1/1/2017	12/31/2999
G9757	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical procedures that included the use of silicone oil	1/1/2017	12/31/2999
G9758	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient in hospice at any time during the measurement period	1/1/2017	12/31/2999
G9761	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9762	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had at least two hpv vaccines (with at least 146 days between the two) or three hpv vaccines on or between the patient's 9th and 13th birthdays	1/1/2017	12/31/2999
G9763	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not have at least two hpv vaccines (with at least 146 days between the two) or three hpv vaccines on or between the patient's 9th and 13th birthdays	1/1/2017	12/31/2999
G9764	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has been treated with a systemic medication for psoriasis vulgaris	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9765	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that the patient declined change in medication or alternative therapies were unavailable, has documented contraindications, or has not been treated with a systemic medication for at least six consecutive months (e.g., experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by pga, bsa, pasi, or dlqi	1/1/2017	12/31/2999
G9766	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are transferred from one institution to another with a known diagnosis of cva for endovascular stroke treatment	1/1/2017	12/31/2999
G9767	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospitalized patients with newly diagnosed cva considered for endovascular stroke treatment	1/1/2017	12/31/2999
G9768	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who utilize hospice services any time during the measurement period	1/1/2017	12/31/2999
G9769	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months	1/1/2017	12/31/2999
G9770	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Peripheral nerve block (pnb)	1/1/2017	12/31/2999
G9771	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) achieved within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9772	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time (e.g., emergency cases, intentional hypothermia, etc.)	1/1/2017	12/31/2999
G9773	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) not achieved within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time, reason not given	1/1/2017	12/31/2999
G9775	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	1/1/2017	12/31/2999
G9776	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)	1/1/2017	12/31/2999
G9777	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	1/1/2017	12/31/2999
G9779	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are breastfeeding at any time during the performance period	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9780	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who have a diagnosis of rhabdomyolysis at any time during the performance period	1/1/2017	12/31/2999
G9781	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not currently being a statin therapy user or receiving an order (prescription) for statin therapy (e.g., patients with statin-associated muscle symptoms or an allergy to statin medication therapy, patients who are receiving palliative or hospice care, patients with active liver disease or hepatic disease or insufficiency, patients with end stage renal disease [esrd], or other medical reasons)	1/1/2017	12/31/2999
G9782	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	History of or active diagnosis of familial hypercholesterolemia	1/1/2017	12/31/2999
G9784	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathologists/dermatopathologists providing a second opinion on a biopsy	1/1/2017	12/31/2999
G9785	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9786	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) was not sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist	1/1/2017	12/31/2999
G9787	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient alive as of the last day of the measurement year	1/1/2017	12/31/2999
G9788	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent bp is less than or equal to 130/80 mm hg	1/1/2017	12/31/2999
G9789	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure recorded during inpatient stays, emergency room visits, or urgent care visits	1/1/2017	12/31/2999
G9790	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent bp is greater than 130/80 mm hg, or blood pressure not documented	1/1/2017	12/31/2999
G9791	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent tobacco status is tobacco free	1/1/2017	12/31/2999
G9792	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent tobacco status is not tobacco free	1/1/2017	12/31/2999
G9793	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is currently on a daily aspirin or other antiplatelet	1/1/2017	12/31/2999
G9794	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g., history of gastrointestinal bleed, intra-cranial bleed, idiopathic thrombocytopenic purpura (itp), gastric bypass or documentation of active anticoagulant use during the measurement period)	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9795	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is not currently on a daily aspirin or other antiplatelet	1/1/2017	12/31/2999
G9796	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is currently on a high intensity statin therapy	1/1/2017	12/31/2999
G9797	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is not on a high intensity statin therapy	1/1/2017	12/31/2999
G9805	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9806	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who received cervical cytology or an hpv test	1/1/2017	12/31/2999
G9807	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not receive cervical cytology or an hpv test	1/1/2017	12/31/2999
G9812	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient died including all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure	1/1/2017	12/31/2999
G9813	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not die within 30 days of the procedure or during the index hospitalization	1/1/2017	12/31/2999
G9818	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of sexual activity	1/1/2017	12/31/2999
G9819	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2017	12/31/2999
G9820	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a chlamydia screening test with proper follow-up	1/1/2017	12/31/2999
G9821	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No documentation of a chlamydia screening test with proper follow-up	1/1/2017	12/31/2999
G9822	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had an endometrial ablation procedure during the 12 months prior to the index date (exclusive of the index date)	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9823	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Endometrial sampling or hysteroscopy with biopsy and results documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation	1/1/2017	12/31/2999
G9824	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Endometrial sampling or hysteroscopy with biopsy and results not documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation	1/1/2017	12/31/2999
G9830	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Her-2/neu positive	1/1/2017	12/31/2999
G9831	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ajcc stage at breast cancer diagnosis = ii or iii	1/1/2017	12/31/2999
G9832	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ajcc stage at breast cancer diagnosis = i (ia or ib) and t-stage at breast cancer diagnosis = t1c	1/1/2017	12/31/2999
G9838	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has metastatic disease at diagnosis	1/1/2017	12/31/2999
G9839	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anti-egfr monoclonal antibody therapy	1/1/2017	12/31/2999
G9840	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ras (kras and nras) gene mutation testing performed before initiation of anti-egfr moab	1/1/2017	12/31/2999
G9841	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ras (kras and nras) gene mutation testing not performed before initiation of anti-egfr moab	1/1/2017	12/31/2999
G9842	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has metastatic disease at diagnosis	1/1/2017	12/31/2999
G9843	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ras (kras or nras) gene mutation	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9844	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive anti-egfr monoclonal antibody therapy	1/1/2017	12/31/2999
G9845	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received anti-egfr monoclonal antibody therapy	1/1/2017	12/31/2999
G9846	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died from cancer	1/1/2017	12/31/2999
G9847	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received systemic cancer-directed therapy in the last 14 days of life	1/1/2017	12/31/2999
G9848	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive systemic cancer-directed therapy in the last 14 days of life	1/1/2017	12/31/2999
G9858	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient enrolled in hospice	1/1/2017	12/31/2999
G9859	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died from cancer	1/1/2017	12/31/2999
G9860	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient spent less than three days in hospice care	1/1/2017	12/31/2999
G9861	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient spent greater than or equal to three days in hospice care	1/1/2017	12/31/2999
G9862	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is = 66 years old, or life expectancy < 10 years old, other medical reasons)	1/1/2017	12/31/2999
G9868	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a medicare-approved cmmi model, less than 10 minutes	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9869	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a medicare-approved cmmi model, 10-20 minutes	1/1/2018	12/31/2999
G9870	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a medicare-approved cmmi model, more than 20 minutes	1/1/2018	12/31/2999
G9873	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3)adheres to a CDC-approved DPP curriculum for core sessions	4/1/2018	12/31/2999
G9874	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9875	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.	4/1/2018	12/31/2999
G9876	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9877	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	4/1/2018	12/31/2999
G9878	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9879	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12	4/1/2018	12/31/2999
G9880	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9881	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.	4/1/2018	12/31/2999
G9882	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9883	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	4/1/2018	12/31/2999
G9884	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21.	4/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9885	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 22-24 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.	4/1/2018	12/31/2999
G9887	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	1/1/2024	12/31/2999
G9888	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Maintenance 5% wl from baseline weight in months 7-12	1/1/2024	12/31/2999
G9890	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary.	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9891	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code.(This code is for reporting purposes only).	1/1/2018	12/31/2999
G9894	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate	1/1/2018	12/31/2999
G9895	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g., salvage therapy)	1/1/2018	12/31/2999
G9896	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate	1/1/2018	12/31/2999
G9897	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not prescribed/administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate, reason not given	1/1/2018	12/31/2999
G9898	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9899	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	1/1/2018	12/31/2999
G9900	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	1/1/2018	12/31/2999
G9901	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period	1/1/2018	12/31/2999
G9902	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco user	1/1/2018	12/31/2999
G9903	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco non-user	1/1/2018	12/31/2999
G9905	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for tobacco use	1/1/2018	12/31/2999
G9906	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	1/1/2018	12/31/2999
G9908	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9910	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period	1/1/2018	12/31/2999
G9911	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy	1/1/2018	12/31/2999
G9912	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hepatitis b virus (hbv) status assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy	1/1/2018	12/31/2999
G9913	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hepatitis b virus (hbv) status not assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy, reason not otherwise specified	1/1/2018	12/31/2999
G9914	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient initiated an anti-tnf agent	1/1/2018	12/31/2999
G9915	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No record of hbv results documented	1/1/2018	12/31/2999
G9916	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status performed once in the last 12 months	1/1/2018	12/31/2999
G9917	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of advanced stage dementia and caregiver knowledge is limited	1/1/2018	12/31/2999
G9918	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status not performed, reason not otherwise specified	1/1/2018	12/31/2999
G9919	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening performed and positive and provision of recommendations	1/1/2018	12/31/2999
G9920	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening performed and negative	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9922	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety concerns screen provided and if positive then documented mitigation recommendations	1/1/2018	12/31/2999
G9923	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety concerns screen provided and negative	1/1/2018	12/31/2999
G9925	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety concerns screening not provided, reason not otherwise specified	1/1/2018	12/31/2999
G9926	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety concerns screening positive screen is without provision of mitigation recommendations, including but not limited to referral to other resources	1/1/2018	12/31/2999
G9928	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fda-approved anticoagulant not prescribed, reason not given	1/1/2018	12/31/2999
G9929	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with transient or reversible cause of af (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)	1/1/2018	12/31/2999
G9930	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are receiving comfort care only	1/1/2018	12/31/2999
G9931	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of cha2ds2-vasc risk score of 0 or 1 for men; or 0, 1, or 2 for women	1/1/2018	12/31/2999
G9938	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients aged 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the six months prior to the measurement period through december 31 of the measurement period	1/1/2018	12/31/2999
G9939	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathologists/dermatopathologists is the same clinician who performed the biopsy	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9940	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not on a statin (e.g., pregnancy, in vitro fertilization, clomiphene rx, esrd, cirrhosis, muscular pain and disease during the measurement period or prior year)	1/1/2018	12/31/2999
G9943	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively	1/1/2018	12/31/2999
G9945	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis	1/1/2018	12/31/2999
G9946	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Back pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively	1/1/2018	12/31/2999
G9949	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively	1/1/2018	12/31/2999
G9954	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient exhibits 2 or more risk factors for post-operative vomiting	1/1/2018	12/31/2999
G9955	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cases in which an inhalational anesthetic is used only for induction	1/1/2018	12/31/2999
G9957	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9958	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	1/1/2018	12/31/2999
G9959	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Systemic antimicrobials not prescribed	1/1/2018	12/31/2999
G9960	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for prescribing systemic antimicrobials	1/1/2018	12/31/2999
G9961	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Systemic antimicrobials prescribed	1/1/2018	12/31/2999
G9962	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy	1/1/2018	12/31/2999
G9963	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy	1/1/2018	12/31/2999
G9964	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received at least one well-child visit with a pcp during the performance period	1/1/2018	12/31/2999
G9965	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive at least one well-child visit with a pcp during the performance period	1/1/2018	12/31/2999
G9968	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was referred to another clinician or specialist during the measurement period	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9969	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred	1/1/2018	12/31/2999
G9970	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9978	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9979	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: An expanded problem focused history;An expanded problem focused examination;Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	1/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9980	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A detailed history;A detailed examination; Medical decision making of low complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9981	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9982	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of high complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9983	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A problem focused history;A problem focused examination;Straightforward medical decision making, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9984	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: An expanded problem focused history;An expanded problem focused examination;Medical decision making of low complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9985	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A detailed history; A detailed examination;Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9986	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:A comprehensive history;A comprehensive examination;Medical decision making of high complexity, furnished in real time using interactive audio and video technology.Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	10/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9987	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bundled Payments for Care Improvement Advanced (BPCI Advanced) model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only for a BPCI Advanced model episode of care; may not be billed for a 30-day period covered by a transitional care management code.	10/1/2018	12/31/2999
G9988	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Palliative care services provided to patient any time during the measurement period	1/1/2022	12/31/2999
G9992	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Palliative care services used by patient any time during the measurement period	1/1/2022	12/31/2999
G9993	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was provided palliative care services any time during the measurement period	1/1/2022	12/31/2999
G9994	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is using palliative care services any time during the measurement period	1/1/2022	12/31/2999
G9996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating the patient has received or is currently receiving palliative or hospice care	1/1/2022	12/31/2999
G9997	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
G9998	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or sessile serrated polyps >= 20 mm in size, last colonoscopy found greater than 10 adenomas, lower gastrointestinal bleeding, or patient at high risk for colon cancer due to underlying medical history ([i.e. crohn's disease, ulcerative colitis, personal or family history of colon cancer, hereditary colorectal cancer syndromes])	1/1/2022	12/31/2999
G9999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report, patient cannot provide precise date or details from previous colonoscopy, previous colonoscopy report was incomplete)	1/1/2022	12/31/2999
H0041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, child, non-therapeutic, per diem	1/1/2023	12/31/2999
H0042	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, child, non-therapeutic, per month	1/1/2023	12/31/2999
H0043	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported housing, per diem	1/1/2023	12/31/2999
H0044	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported housing, per month	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
H0046	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Mental health services, not otherwise specified	7/1/2008	12/31/2999
H0047	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Alcohol and/or other drug abuse services, not otherwise specified	7/1/2008	12/31/2999
H0051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Traditional healing service	4/1/2024	12/31/2999
H1010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-medical family planning education, per session	1/1/2023	12/31/2999
H2015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Comprehensive community support services, per 15 minutes	1/1/2021	12/31/2999
H2021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community-based wrap-around services, per 15 minutes	1/1/2021	12/31/2999
H2023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported employment, per 15 minutes	1/1/2023	12/31/2999
H2024	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supported employment, per diem	1/1/2023	12/31/2999
H2025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing support to maintain employment, per 15 minutes	1/1/2023	12/31/2999
H2026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing support to maintain employment, per diem	1/1/2023	12/31/2999
H2030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health clubhouse services, per 15 minutes	1/1/2023	12/31/2999
H2031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mental health clubhouse services, per diem	1/1/2023	12/31/2999
H2038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Skills training and development, per diem	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Esketamine, nasal spray, 1 mg	1/1/2026	12/31/2999
J0177	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept hd, 1 mg	4/1/2024	12/31/2999
J0178	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept, 1 mg	1/1/2013	12/31/2999
J0179	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, brolucizumab-dbll, 1 mg	8/15/2023	12/31/2999
J0217	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, velmanase alfa-tycv, 1 mg	1/1/2024	12/31/2999
J0220	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	1/1/2013	12/31/2999
J0220	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J0248	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, remdesivir, 1mg	5/1/2024	12/31/2999
J0256	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), NOT OTHERWISE SPECIFIED, 10 MG	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0270	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, alprostadil, 1. 25 mcg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	12/15/2014	12/31/2999
J0275	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alprostadil urethral suppository (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	12/15/2014	12/31/2999
J0470	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, dimercaprol, per 100 mg	1/1/2013	12/31/2999
J0589	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, daxibotulinumtoxina-lanm, 1 unit	4/1/2024	12/31/2999
J0591	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, deoxycholic acid, 1 mg	7/1/2020	12/31/2999
J0593	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)	10/1/2019	12/31/2999
J0599	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	1/1/2019	12/31/2999
J0600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, edetate calcium disodium, up to 1000 mg	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J0870	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, imetelstat, 1 mg	1/1/2025	12/31/2999
J0895	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, deferoxamine mesylate, 500 mg	1/1/2013	12/31/2999
J0897	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, DENOSUMAB, 1 MG	8/1/2022	12/31/2999
J1071	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone cypionate, 1mg	8/1/2018	12/31/2999
J1072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone cypionate (azmiro), 1 mg	4/1/2025	12/31/2999
J1073	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Testosterone pellet, implant, 75 mg	1/1/2026	12/31/2999
J1096	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	9/1/2020	12/31/2999
J1304	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tofersen, 1 mg	1/1/2024	12/31/2999
J1323	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, elranatamab-bcmm, 1 mg	4/1/2024	12/31/2999
J1440	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fecal microbiota, live - jslm, 1 ml	7/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1442	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram	10/1/2021	12/31/2999
J1447	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tbo-filgrastim, 1 microgram	10/1/2021	12/31/2999
J1566	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, immune globulin, intravenous, lyophilized (e. G. Powder), not otherwise specified, 500 mg	10/24/2019	12/31/2999
J1599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG	10/24/2019	12/31/2999
J1726	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, (makena), 10 mg	7/15/2023	12/31/2999
J1729	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	10/24/2019	12/31/2999
J1729	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	7/15/2023	12/31/2999
J1748	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, infliximab-dyyb (zymfentra), 10 mg	7/1/2024	12/31/2999
J1932	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, lanreotide, (cipla), 1 mg	10/1/2022	12/31/2999
J1950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, leuprolide acetate (for depot suspension), per 3. 75 mg	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J1952	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leuprolide injectable, camcevi, 1 mg	1/1/2022	12/31/2999
J2440	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, papaverine hcl, up to 60 mg	1/1/2013	12/31/2999
J2506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	1/1/2022	12/31/2999
J2777	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, faricimab-svoa, 0.1 mg	10/1/2022	12/31/2999
J2778	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, RANIBIZUMAB, 0.1 MG	1/1/2013	12/31/2999
J2779	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg	7/1/2022	12/31/2999
J2781	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegcetacoplan, intravitreal, 1 mg	10/1/2023	12/31/2999
J2782	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, avacincaptad pegol, 0.1 mg	4/1/2024	12/31/2999
J2820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sargramostim (gm-csf), 50 mcg	10/1/2021	12/31/2999
J3055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, talquetamab-tgvs, 0.25 mg	4/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone enanthate, 1mg	10/1/2024	12/31/2999
J3145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, testosterone undecanoate, 1 mg	10/1/2024	12/31/2999
J3299	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, triamcinolone acetonide (xipere), 1 mg	7/1/2022	12/31/2999
J3316	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, triptorelin, extended-release, 3.75 mg	10/1/2024	12/31/2999
J3387	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, elivaldogene autotemcel, per treatment	1/1/2026	3/31/2026
J3389	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Topical administration, prademagene zamikeracel, per treatment	1/1/2026	3/31/2026
J3403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Revakinagene taroretcel-lwey, per implant	10/1/2025	12/31/2999
J3490	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drugs	1/1/1950	12/31/2999
J3520	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Edetate disodium, per 150 mg	1/1/2013	12/31/2999
J3570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laetrile, amygdalin, vitamin b17	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J3590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified biologics	1/1/1950	12/31/2999
J3591	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unclassified drug or biological used for esrd on dialysis	1/1/2019	12/31/2999
J7192	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U., NOT OTHERWISE SPECIFIED	10/24/2019	12/31/2999
J7195	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified	10/24/2019	12/31/2999
J7199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hemophilia clotting factor, not otherwise classified	1/1/1950	12/31/2999
J7308	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form (354 mg)	1/1/2013	12/31/2999
J7311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg	1/1/2013	12/31/2999
J7312	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, DEXAMETHASONE, INTRAVITREAL IMPLANT, 0.1 MG	1/1/2013	12/31/2999
J7313	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	1/1/2016	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7314	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	10/1/2019	12/31/2999
J7340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml	10/1/2024	12/31/2999
J7345	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	9/1/2020	12/31/2999
J7351	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bimatoprost, intracameral implant, 1 microgram	10/1/2020	12/31/2999
J7355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, travoprost, intracameral implant, 1 microgram	7/1/2024	12/31/2999
J7356	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg	7/1/2025	12/31/2999
J7402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mometasone furoate sinus implant, (sinuva), 10 micrograms	4/1/2021	12/31/2999
J7508	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg	1/1/2014	12/31/2999
J7599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Immunosuppressive drug, not otherwise classified	1/1/1950	12/31/2999
J7604	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7607	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	1/1/2020	12/31/2999
J7609	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	1/1/2020	12/31/2999
J7610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	1/1/2020	12/31/2999
J7615	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	1/1/2020	12/31/2999
J7622	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7624	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7627	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG	1/1/2020	12/31/2999
J7628	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7629	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7632	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH	1/1/2020	12/31/2999
J7634	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM	1/1/2020	12/31/2999
J7635	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7636	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7637	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7638	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7640	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7641	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM	1/1/2020	12/31/2999
J7642	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7643	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7645	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7647	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7650	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7657	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7660	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7667	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	1/1/2020	12/31/2999
J7670	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	1/1/2020	12/31/2999
J7676	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED	1/1/2020	12/31/2999
J7680	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7681	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7683	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7684	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	1/1/2020	12/31/2999
J7685	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J7699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, inhalation solution administered through dme	1/1/1950	12/31/2999
J7799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Noc drugs, other than inhalation drugs, administered through dme	1/1/1950	12/31/2999
J7999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Compounded drug, not otherwise classified	1/1/2016	12/31/2999
J8498	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, RECTAL/SUPPOSITORY, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, non chemotherapeutic, nos	1/1/1950	12/31/2999
J8597	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ANTIEMETIC DRUG, ORAL, NOT OTHERWISE SPECIFIED	1/1/2006	12/31/2999
J8999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prescription drug, oral, chemotherapeutic, nos	1/1/1950	12/31/2999
J9021	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	1/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tarlatamab-dlle, 1 mg	1/1/2025	12/31/2999
J9028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	1/1/2025	12/31/2999
J9029	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	7/1/2023	12/31/2999
J9032	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, belinostat, 10 mg	1/1/2016	12/31/2999
J9036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	7/1/2019	12/31/2999
J9038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, axatilimab-csfr, 0.1 mg	4/1/2025	12/31/2999
J9054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bortezomib (boruzu), 0.1 mg	4/1/2025	12/31/2999
J9056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bendamustine hydrochloride (vivimusta), 1 mg	7/1/2023	12/31/2999
J9061	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, amivantamab-vmjw, 2 mg	1/1/2022	12/31/2999
J9153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, DEGARELIX, 1 MG	1/1/2013	12/31/2999
J9174	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, docetaxel (beizray), 1 mg	7/1/2025	12/31/2999
J9184	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, gemcitabine hydrochloride (avyxa), 200 mg	1/1/2026	12/31/2999
J9202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Goserelin acetate implant, per 3. 6 mg	1/1/2013	12/31/2999
J9206	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, IRINOTECAN, 20 MG	4/1/2020	12/31/2999
J9225	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Histrelin implant (vantas), 50 mg	1/1/2013	12/31/2999
J9226	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HISTRELIN IMPLANT (SUPPRELIN LA), 50 MG	1/1/2013	12/31/2999
J9256	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, nipocalimab-aahu, 3 mg	1/1/2026	3/31/2026
J9262	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, omacetaxine mepesuccinate, 0.01 mg	1/1/2014	12/31/2999
J9272	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, dostarlimab-gxly, 10 mg	1/1/2022	12/31/2999
J9273	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tisotumab vedotin-tftv, 1 mg	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9274	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, tebentafusp-tebn, 1 microgram	10/1/2022	12/31/2999
J9282	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mitomycin, intravesical instillation, 1 mg	1/1/2026	3/31/2026
J9285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, olaratumab, 10 mg	9/1/2019	12/31/2999
J9286	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, glofitamab-gxbm, 2.5 mg	1/1/2024	12/31/2999
J9295	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, necitumumab, 1 mg	1/1/2017	12/31/2999
J9311	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, rituximab 10 mg and hyaluronidase	1/1/2019	12/31/2999
J9321	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, epcoritamab-bysp, 0.16 mg	1/1/2024	12/31/2999
J9325	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, talimogene laherparepvec, per 1 million plaque forming units	1/1/2017	12/31/2999
J9326	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, telisotuzumab vedotin-tllv, 1 mg	1/1/2026	3/31/2026
J9331	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sirolimus protein-bound particles, 1 mg	7/1/2022	12/31/2999
J9341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, thiotepa (tepylute), 1 mg	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
J9342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, thiotepa, not otherwise specified, 1 mg	7/1/2025	12/31/2999
J9350	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, mosunetuzumab-axgb, 1 mg	7/1/2023	12/31/2999
J9359	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, loncastuximab tesirine-lpyl, 0.075 mg	4/1/2022	12/31/2999
J9380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, teclistamab-cqyv, 0.5 mg	7/1/2023	12/31/2999
J9381	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, teplizumab-mzwv, 5 mcg	8/1/2023	12/31/2999
J9400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, ziv-aflibercept, 1 mg	1/1/2014	12/31/2999
J9600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, PORFIMER SODIUM, 75 MG	1/1/2013	12/31/2999
J9999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, antineoplastic drugs	1/1/1950	12/31/2999
K0002	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard hemi (low seat) wheelchair	6/1/2015	12/31/2999
K0003	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight wheelchair	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0004	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	High strength, lightweight wheelchair	1/1/2013	12/31/2999
K0005	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ultralightweight wheelchair	1/1/2013	12/31/2999
K0006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Heavy duty wheelchair	1/1/2013	12/31/2999
K0007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Extra heavy duty wheelchair	1/1/2013	12/31/2999
K0008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom Manual Wheelchair/Base	7/1/2013	12/31/2999
K0009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Other manual wheelchair/base	1/1/2013	12/31/2999
K0010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair	1/1/2013	12/31/2999
K0011	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	1/1/2013	12/31/2999
K0012	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lightweight portable motorized/power wheelchair	1/1/2013	12/31/2999
K0013	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom Motorized/Power Wheelchair Base	7/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0014	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Other motorized/power wheelchair base	1/1/2013	12/31/2999
K0046	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elevating legrest, lower extension tube, replacement only, each	11/15/2020	12/31/2999
K0047	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elevating legrest, upper hanger bracket, replacement only, each	11/15/2020	12/31/2999
K0051	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cam release assembly, footrest or legrest, replacement only, each	11/15/2020	12/31/2999
K0053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elevating footrests, articulating (telescoping), each	1/1/2013	12/31/2999
K0056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat height less than 17 or equal to or greater than 21 for a high strength, lightweight, or ultralightweight wheelchair	1/1/2013	12/31/2999
K0065	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Spoke protectors, each	1/1/2021	12/31/2999
K0070	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	11/15/2020	12/31/2999
K0071	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Front caster assembly, complete, with pneumatic tire, replacement only, each	11/15/2020	12/31/2999
K0072	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Front caster assembly, complete, with semi-pneumatic tire, replacement only, each	11/15/2020	12/31/2999
K0108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wheelchair component or accessory, not otherwise specified	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0108	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Wheelchair component or accessory, not otherwise specified	2/9/2017	12/31/2999
K0195	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elevating leg rests, pair (for use with capped rental wheelchair base)	11/15/2020	12/31/2999
K0455	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Infusion pump used for uninterrupted parenteral administration of medication, (e. G. , epoprostenol or treprostinol)	2/1/2015	12/31/2999
K0462	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Temporary replacement for patient owned equipment being repaired, any type	11/15/2020	12/31/2999
K0669	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Seat/back custom; no dme pdac ver	1/1/2013	12/31/2999
K0743	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS	1/1/2013	12/31/2999
K0744	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS	1/1/2013	12/31/2999
K0745	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES	1/1/2013	12/31/2999
K0746	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0800	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0801	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0802	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0806	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0807	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0808	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	1/1/2013	12/31/2999
K0812	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	2/9/2017	12/31/2999
K0813	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0815	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0820	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0821	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0823	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0825	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0827	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0829	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0831	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0835	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0836	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0837	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0838	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0839	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0842	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0843	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0849	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0850	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0851	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0852	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0853	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0854	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0855	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0857	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0861	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0862	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0863	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0864	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	1/1/2013	12/31/2999
K0868	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0869	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0870	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0871	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0877	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0878	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0879	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	1/1/2013	12/31/2999
K0884	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K0885	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	1/1/2013	12/31/2999
K0886	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	1/1/2013	12/31/2999
K0890	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	1/1/2013	12/31/2999
K0891	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	1/1/2013	12/31/2999
K0898	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	1/1/2013	12/31/2999
K0898	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	10/1/2006	12/31/2999
K0899	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power mobile device; no dme pdac	1/1/2013	12/31/2999
K0900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Customized Durable Medical Equipment, Other Than Wheelchair	7/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
K1004	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Low frequency ultrasonic diathermy treatment device for home use	12/1/2020	12/31/2999
K1007	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	3/1/2021	12/31/2999
K1027	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	10/1/2021	12/31/2999
K1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	4/1/2022	12/31/2999
K1035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Molecular diagnostic test reader, nonprescription self-administered and self-collected use, fda approved, authorized or cleared	4/1/2023	12/31/2999
K1036	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month	10/1/2023	12/31/2999
K1037	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	10/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L0999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Addition to spinal orthosis, not otherwise specified	10/24/2019	12/31/2999
L1499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Spinal orthosis, not otherwise specified	1/1/1950	12/31/2999
L1834	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, without knee joint, rigid, custom-fabricated	1/1/2013	12/31/2999
L1840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated	1/1/2013	12/31/2999
L1844	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	1/1/2013	12/31/2999
L1846	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	1/1/2013	12/31/2999
L1860	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee orthosis, modification of supracondylar prosthetic socket, custom-fabricated (sk)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L2006	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Knee ankle foot device, any material, single or double upright, swing and stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated	1/1/2020	12/31/2999
L2999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity orthoses, not otherwise specified	1/1/1950	12/31/2999
L3000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, 'ucb' type, berkeley shell, each	1/1/2013	12/31/2999
L3001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, spenco, each	1/1/2013	12/31/2999
L3002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, plastazote or equal, each	1/1/2013	12/31/2999
L3003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, silicone gel, each	1/1/2013	12/31/2999
L3010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, longitudinal arch support, each	1/1/2013	12/31/2999
L3020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each	1/1/2013	12/31/2999
L3030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert, removable, formed to patient foot, each	1/1/2013	12/31/2999
L3031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each	1/1/2013	12/31/2999
L3040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal, each	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, metatarsal, each	1/1/2013	12/31/2999
L3060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, removable, premolded, longitudinal/ metatarsal, each	1/1/2013	12/31/2999
L3070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, longitudinal, each	1/1/2013	12/31/2999
L3080	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, metatarsal, each	1/1/2013	12/31/2999
L3090	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each	1/1/2013	12/31/2999
L3100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hallus-valgus night dynamic splint, prefabricated, off-the-shelf	1/1/2013	12/31/2999
L3140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, abduction rotation bar, including shoes	1/1/2013	12/31/2999
L3150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, abduction rotatation bar, without shoes	1/1/2013	12/31/2999
L3160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, adjustable shoe-styled positioning device	1/1/2013	12/31/2999
L3170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, plastic, silicone or equal, heel stabilizer, prafabricated, off-the-shelf, each	1/1/2013	12/31/2999
L3201	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, infant	1/1/2013	12/31/2999
L3202	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, child	1/1/2013	12/31/2999
L3203	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, oxford with supinator or pronator, junior	1/1/2013	12/31/2999
L3204	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, infant	1/1/2013	12/31/2999
L3206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, child	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, hightop with supinator or pronator, junior	1/1/2013	12/31/2999
L3212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, infant	1/1/2014	12/31/2999
L3213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, child	1/1/2014	12/31/2999
L3214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Benesch boot, pair, junior	1/1/2014	12/31/2999
L3215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH	1/1/2014	12/31/2999
L3216	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH	1/1/2014	12/31/2999
L3217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	1/1/2014	12/31/2999
L3219	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH	1/1/2014	12/31/2999
L3221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH	1/1/2014	12/31/2999
L3222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH	1/1/2014	12/31/2999
L3230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH	1/1/2014	12/31/2999
L3250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	1/1/2014	12/31/2999
L3251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, shoe molded to patient model, silicone shoe, each	1/1/2014	12/31/2999
L3252	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each	1/1/2014	12/31/2999
L3253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foot, molded shoe plastazote (or similar) custom fitted, each	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-standard size or width	1/1/2014	12/31/2999
L3255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-standard size or length	1/1/2014	12/31/2999
L3257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic footwear, additional charge for split size	1/1/2014	12/31/2999
L3265	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Plastazote sandal, each	1/1/2014	12/31/2999
L3300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel, tapered to metatarsals, per inch	1/1/2014	12/31/2999
L3310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel and sole, neoprene, per inch	1/1/2014	12/31/2999
L3320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel and sole, cork, per inch	1/1/2014	12/31/2999
L3330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, metal extension (skate)	1/1/2014	12/31/2999
L3332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, inside shoe, tapered, up to one-half inch	1/1/2014	12/31/2999
L3334	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lift, elevation, heel, per inch	1/1/2014	12/31/2999
L3340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel wedge, sach	1/1/2014	12/31/2999
L3350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel wedge	1/1/2014	12/31/2999
L3360	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sole wedge, outside sole	1/1/2014	12/31/2999
L3370	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sole wedge, between sole	1/1/2014	12/31/2999
L3380	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Clubfoot wedge	1/1/2014	12/31/2999
L3390	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Outflare wedge	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3400	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Metatarsal bar wedge, rocker	1/1/2014	12/31/2999
L3410	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Metatarsal bar wedge, between sole	1/1/2014	12/31/2999
L3420	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Full sole and heel wedge, between sole	1/1/2014	12/31/2999
L3430	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, counter, plastic reinforced	1/1/2014	12/31/2999
L3440	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, counter, leather reinforced	1/1/2014	12/31/2999
L3450	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, sach cushion type	1/1/2014	12/31/2999
L3455	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, new leather, standard	1/1/2014	12/31/2999
L3460	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, new rubber, standard	1/1/2014	12/31/2999
L3465	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, thomas with wedge	1/1/2014	12/31/2999
L3470	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, thomas extended to ball	1/1/2014	12/31/2999
L3480	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, pad and depression for spur	1/1/2014	12/31/2999
L3485	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Heel, pad, removable for spur	1/1/2014	12/31/2999
L3500	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, leather	1/1/2014	12/31/2999
L3510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, rubber	1/1/2014	12/31/2999
L3520	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, insole, felt covered with leather	1/1/2014	12/31/2999
L3530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, sole, half	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, sole, full	1/1/2014	12/31/2999
L3550	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, toe tap standard	1/1/2014	12/31/2999
L3560	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, toe tap, horseshoe	1/1/2014	12/31/2999
L3570	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, special extension to instep (leather with eyelets)	1/1/2014	12/31/2999
L3580	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, convert instep to velcro closure	1/1/2014	12/31/2999
L3590	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, convert firm shoe counter to soft counter	1/1/2014	12/31/2999
L3595	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe addition, march bar	1/1/2014	12/31/2999
L3600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, caliper plate, existing	1/1/2014	12/31/2999
L3610	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, caliper plate, new	1/1/2014	12/31/2999
L3620	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, solid stirrup, existing	1/1/2014	12/31/2999
L3630	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, solid stirrup, new	1/1/2014	12/31/2999
L3640	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transfer of an orthosis from one shoe to another, dennis browne splint (riveton), both shoes	1/1/2014	12/31/2999
L3649	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Orthopedic shoe, modification, addition or transfer, not otherwise specified	1/1/1950	12/31/2999
L3649	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Orthopedic shoe, modification, addition or transfer, not otherwise specified	1/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L3999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper limb orthosis, not otherwise specified	1/1/1950	12/31/2999
L5610	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee, hydracadence system	1/1/2013	12/31/2999
L5611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control	1/1/2013	12/31/2999
L5613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control	1/1/2013	12/31/2999
L5614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control	1/1/2013	12/31/2999
L5615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	1/1/2024	12/31/2999
L5616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control	1/1/2013	12/31/2999
L5620	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, test socket, below knee	1/1/2013	12/31/2999
L5624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, test socket, above knee	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, acrylic socket	1/1/2013	12/31/2999
L5631	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	1/1/2013	12/31/2999
L5638	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, leather socket	1/1/2013	12/31/2999
L5639	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, wood socket	1/1/2013	12/31/2999
L5640	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, knee disarticulation, leather socket	1/1/2013	12/31/2999
L5642	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, leather socket	1/1/2013	12/31/2999
L5644	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, wood socket	1/1/2013	12/31/2999
L5645	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, flexible inner socket, external frame	1/1/2013	12/31/2999
L5646	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	1/1/2013	12/31/2999
L5647	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee suction socket	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5648	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	1/1/2013	12/31/2999
L5651	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, above knee, flexible inner socket, external frame	1/1/2013	12/31/2999
L5652	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	1/1/2013	12/31/2999
L5657	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, manual/automated adjustable air, fluid, gel or equal socket insert for limb volume management, any materials	10/1/2025	12/31/2999
L5670	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar)	1/1/2013	12/31/2999
L5671	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee / above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert	12/1/2019	12/31/2999
L5672	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee, removable medial brim suspension	12/1/2019	12/31/2999
L5673	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric, or equal, with or without perforations, with or without breathable material, for use with locking mechanism	12/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5704	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, below knee	1/1/2013	12/31/2999
L5705	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, above knee	1/1/2013	12/31/2999
L5706	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, knee disarticulation	1/1/2013	12/31/2999
L5707	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Custom shaped protective cover, hip disarticulation	9/1/2024	12/31/2999
L5714	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	1/1/2013	12/31/2999
L5722	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	1/1/2013	12/31/2999
L5724	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	1/1/2013	12/31/2999
L5726	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	1/1/2013	12/31/2999
L5728	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	1/1/2013	12/31/2999
L5780	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5785	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	1/1/2013	12/31/2999
L5790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	1/1/2013	12/31/2999
L5795	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	1/1/2013	12/31/2999
L5814	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	1/1/2013	12/31/2999
L5816	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	1/1/2013	12/31/2999
L5818	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	1/1/2013	12/31/2999
L5822	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	1/1/2013	12/31/2999
L5824	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	1/1/2013	12/31/2999
L5826	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	1/1/2013	12/31/2999
L5827	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5828	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	1/1/2013	12/31/2999
L5830	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control	1/1/2013	12/31/2999
L5840	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	1/1/2015	12/31/2999
L5841	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control	4/1/2024	12/31/2999
L5848	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY	1/1/2013	12/31/2999
L5856	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	1/1/2013	12/31/2999
L5857	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	9/1/2020	12/31/2999
L5858	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5859	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	1/1/2013	12/31/2999
L5926	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	1/1/2024	12/31/2999
L5961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	1/1/2013	12/31/2999
L5962	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	1/1/2013	12/31/2999
L5964	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	1/1/2013	12/31/2999
L5966	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	1/1/2013	12/31/2999
L5968	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	4/15/2015	12/31/2999
L5969	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	12/1/2019	12/31/2999
L5970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, external keel, sach foot	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5973	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	9/1/2020	12/31/2999
L5976	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)	1/1/2013	12/31/2999
L5978	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, foot, multiaxial ankle/foot	1/1/2013	12/31/2999
L5979	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system	1/1/2013	12/31/2999
L5980	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, flex foot system	1/1/2013	12/31/2999
L5981	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, flex-walk system or equal	1/1/2013	12/31/2999
L5982	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All exoskeletal lower extremity prostheses, axial rotation unit	1/1/2013	12/31/2999
L5984	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	1/1/2013	12/31/2999
L5985	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	1/1/2013	12/31/2999
L5986	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L5987	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	All lower extremity prosthesis, shank foot system with vertical loading pylon	1/1/2013	12/31/2999
L5991	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Addition to lower extremity prostheses, osseointegrated external prosthetic connector	10/1/2023	12/31/2999
L5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lower extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L6026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	1/1/2015	12/31/2999
L6034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Partial hand, finger, and thumb prosthesis without prosthetic digit(s)/thumb, amputation at distal to metacarpal joint, including flexible or non-flexible interface, molded to patient model, for use without external power and/or passive prosthetic digit/thumb, not including inserts described by l6692	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Single prosthetic digit, mechanical, can include metacarpophalangeal (mcp), proximal interphalangeal (pip), and/or distal interphalangeal (dip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement	10/1/2025	12/31/2999
L6036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Prosthetic thumb, mechanical, can include metacarpophalangeal (mcp), interphalangeal (ip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement	10/1/2025	12/31/2999
L6038	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Addition to single prosthetic digit or thumb, mechanical, attachment, multiaxial and/or internal/external rotation/abduction/adduction mechanism, with or without locking feature, any material	10/1/2025	12/31/2999
L6039	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Passive prosthetic digit or thumb prosthesis not including hand restoration partial hand, full or partial, custom made, any material, initial or replacement, per single passive prosthetic digit or thumb	10/1/2025	12/31/2999
L6611	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE	1/1/2013	12/31/2999
L6621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6646	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system	12/1/2016	12/31/2999
L6648	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, shoulder lock mechanism, external powered actuator	12/1/2016	12/31/2999
L6700	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement	4/1/2025	12/31/2999
L6715	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT	9/1/2020	12/31/2999
L6880	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	2/15/2014	12/31/2999
L6881	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AUTOMATIC GRASP FEATURE, ADDITION TO UPPER LIMB ELECTRIC PROSTHETIC TERMINAL DEVICE	1/1/2013	12/31/2999
L6882	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control feature, addition to upper limb prosthetic terminal device	2/15/2014	12/31/2999
L6883	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	REPLACEMENT SOCKET, BELOW ELBOW/WRIST DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6884	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	REPLACEMENT SOCKET, ABOVE ELBOW/ELBOW DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	1/1/2013	12/31/2999
L6885	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER	2/15/2014	12/31/2999
L6920	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999
L6925	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999
L6930	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999
L6935	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6940	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999
L6945	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999
L6950	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999
L6955	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999
L6960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L6965	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999
L6970	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device	2/15/2014	12/31/2999
L6975	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	2/15/2014	12/31/2999
L7007	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	2/15/2014	12/31/2999
L7008	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	2/15/2014	12/31/2999
L7009	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	2/15/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PREHENSILE ACTUATOR, SWITCH CONTROLLED	2/15/2014	12/31/2999
L7045	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC	2/15/2014	12/31/2999
L7170	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, hosmer or equal, switch controlled	2/15/2014	12/31/2999
L7180	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, microprocessor sequential control of elbow and terminal device	2/15/2014	12/31/2999
L7181	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE	2/15/2014	12/31/2999
L7185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, adolescent, variety village or equal, switch controlled	2/15/2014	12/31/2999
L7186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, child, variety village or equal, switch controlled	2/15/2014	12/31/2999
L7190	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled	2/15/2014	12/31/2999
L7191	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic elbow, child, variety village or equal, myoelectronically controlled	2/15/2014	12/31/2999
L7259	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electronic wrist rotator, any type	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L7360	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Six volt battery, each	1/1/2015	12/31/2999
L7362	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger, six volt, each	1/1/2015	12/31/2999
L7364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Twelve volt battery, each	12/1/2016	12/31/2999
L7366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery charger, twelve volt, each	12/1/2016	12/31/2999
L7367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lithium ion battery, rechargeable, replacement	1/1/2015	12/31/2999
L7368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY	1/1/2015	12/31/2999
L7499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Upper extremity prosthesis, not otherwise specified	1/1/1950	12/31/2999
L7900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Male vacuum erection system	1/1/2013	12/31/2999
L7902	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tension ring, for vacuum erection device, any type, replacement only, each	6/15/2022	12/31/2999
L8039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Breast prosthesis, not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8048	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unspecified maxillofacial prosthesis, by report, provided by a non-physician	1/1/1950	12/31/2999
L8499	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Unlisted procedure for miscellaneous prosthetic services	1/1/1950	12/31/2999
L8600	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Implantable breast prosthesis, silicone or equal	9/15/2016	12/31/2999
L8603	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies	5/15/2024	12/31/2999
L8604	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	1/1/2013	12/31/2999
L8605	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	12/1/2020	12/31/2999
L8606	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	1/1/2013	12/31/2999
L8609	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ARTIFICIAL CORNEA	1/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8612	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aqueous shunt	3/15/2015	12/31/2999
L8613	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ossicula implant	6/15/2022	12/31/2999
L8614	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	1/1/2013	12/31/2999
L8615	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HEADSET/HEADPIECE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	1/1/2013	12/31/2999
L8616	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MICROPHONE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	1/1/2013	12/31/2999
L8617	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSMITTING COIL FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	1/1/2013	12/31/2999
L8618	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement	1/1/2013	12/31/2999
L8619	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT	1/1/2013	12/31/2999
L8621	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	1/1/2013	12/31/2999
L8622	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ALKALINE BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE, ANY SIZE, REPLACEMENT, EACH	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8623	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH	1/1/2013	12/31/2999
L8624	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each	1/1/2013	12/31/2999
L8625	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	1/1/2018	12/31/2999
L8627	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT	1/1/2013	12/31/2999
L8628	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT	1/1/2013	12/31/2999
L8629	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	1/1/2013	12/31/2999
L8678	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month	7/15/2023	12/31/2999
L8684	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	1/1/2013	12/31/2999
L8690	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8691	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each	1/1/2013	12/31/2999
L8692	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT	1/1/2013	12/31/2999
L8693	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY	1/1/2013	12/31/2999
L8694	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Auditory osseointegrated device, transducer/actuator, replacement only, each	1/1/2018	12/31/2999
L8698	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Miscellaneous component, supply or accessory for use with total artificial heart system	1/1/2019	12/31/2999
L8699	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic implant, not otherwise specified	1/1/1950	12/31/2999
L8701	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	1/1/2019	12/31/2999
L8702	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
L8720	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg	10/1/2024	12/31/2999
L8721	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receptor sole for use with l8720, replacement, each	10/1/2024	12/31/2999
M0001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Advancing cancer care mips value pathways	1/1/2023	12/31/2999
M0002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Optimal care for kidney health mips value pathways	1/1/2023	12/31/2999
M0004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Quality care for patients with neurological conditions mips value pathway	1/1/2023	12/31/2999
M0005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Value in primary care mips value pathway	1/1/2023	12/31/2999
M0010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enhancing oncology model (eom) monthly enhanced oncology services (meos) payment for eom enhanced services	4/1/2023	12/31/2999
M0075	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cellular therapy	9/1/2020	12/31/2999
M0076	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Prolotherapy	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M0224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring	3/22/2024	12/31/2999
M0300	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Iv chelation therapy (chemical endarterectomy)	1/1/2013	12/31/2999
M0301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fabric wrapping of abdominal aneurysm	1/1/2013	12/31/2999
M1003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tb screening performed and results interpreted within twelve months prior to initiation of first-time biologic and/or immune response modifier therapy	1/1/2019	12/31/2999
M1004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason for not screening for tb or interpreting results (i.e., patient positive for tb and documentation of past treatment; patient who has recently completed a course of anti-tb therapy)	1/1/2019	12/31/2999
M1005	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tb screening not performed or results not interpreted, reason not given	1/1/2019	12/31/2999
M1006	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Disease activity not assessed, reason not given	1/1/2019	12/31/2999
M1007	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	>=50% of total number of a patient's outpatient ra encounters assessed	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1008	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	<50% of total number of a patient's outpatient ra encounters assessed	1/1/2019	12/31/2999
M1009	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1010	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Discharge/discontinuation of the episode of care documented in the medical record	1/1/2019	12/31/2999
M1016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Female patients unable to bear children	1/1/2019	12/31/2999
M1018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with an active diagnosis or history of cancer (except basal cell and squamous cell skin carcinoma), patients who are heavy tobacco smokers, lung cancer screening patients	1/1/2019	12/31/2999
M1019	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adolescent patients 12 to 17 years of age with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adolescent patients 12 to 17 years of age with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq-9 or phq-9m score was not assessed or is greater than or equal to 5	1/1/2019	12/31/2999
M1021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had only urgent care visits during the performance period	1/1/2019	12/31/2999
M1027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Imaging of the head (ct or mri) was obtained	1/1/2019	12/31/2999
M1028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patients with primary headache diagnosis and imaging other than ct or mri obtained	1/1/2019	12/31/2999
M1029	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Imaging of the head (ct or mri) was not obtained, reason not given	1/1/2019	12/31/2999
M1032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adults currently taking pharmacotherapy for oud	1/1/2019	12/31/2999
M1034	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days	1/1/2019	12/31/2999
M1035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adults who are deliberately phased out of medication assisted treatment (mat) prior to 180 days of continuous treatment	1/1/2019	12/31/2999
M1036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adults who have not had at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days	1/1/2019	12/31/2999
M1037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of lumbar spine region cancer at the time of the procedure	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of lumbar spine region fracture at the time of the procedure	1/1/2019	12/31/2999
M1039	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of lumbar spine region infection at the time of the procedure	1/1/2019	12/31/2999
M1040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of lumbar idiopathic or congenital scoliosis	1/1/2019	12/31/2999
M1041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis	1/1/2019	12/31/2999
M1043	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status was not measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively	1/1/2019	12/31/2999
M1045	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was greater than or equal to 37 or knee injury and osteoarthritis outcome score joint replacement (koos, jr.) was greater than or equal to 71	1/1/2019	12/31/2999
M1046	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was less than 37 or the knee injury and osteoarthritis outcome score joint replacement (koos, jr.) was less than 71 postoperatively	1/1/2019	12/31/2999
M1049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status was not measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis	1/1/2019	12/31/2999
M1052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively	1/1/2019	12/31/2999
M1054	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had only urgent care visits during the performance period	1/1/2019	12/31/2999
M1055	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy used	1/1/2019	12/31/2999
M1056	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prescribed anticoagulant medication during the performance period, history of gi bleeding, history of intracranial bleeding, bleeding disorder and specific provider documented reasons: allergy to aspirin or anti-platelets, use of non-steroidal anti-inflammatory agents, drug-drug interaction, uncontrolled hypertension > 180/110 mmhg or gastroesophageal reflux disease	1/1/2019	12/31/2999
M1057	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Aspirin or another antiplatelet therapy not used, reason not given	1/1/2019	12/31/2999
M1058	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was a permanent nursing home resident at any time during the performance period	1/1/2019	12/31/2999
M1059	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient was in hospice or receiving palliative care at any time during the performance period	1/1/2019	12/31/2999
M1060	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient died prior to the end of the performance period	1/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1067	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services for patient provided any time during the measurement period	1/1/2019	12/31/2999
M1068	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adults who are not ambulatory	1/1/2019	12/31/2999
M1069	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for future fall risk	1/1/2019	12/31/2999
M1070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for future fall risk, reason not given	1/1/2019	12/31/2999
M1106	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999
M1107	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
M1108	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999
M1109	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999
M1110	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1111	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999
M1112	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
M1113	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999
M1114	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999
M1115	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999
M1116	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999
M1117	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1118	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999
M1119	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999
M1120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999
M1121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999
M1122	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
M1123	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1124	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999
M1125	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999
M1126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999
M1127	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
M1128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999
M1129	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999
M1131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care	1/1/2020	12/31/2999
M1132	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2020	12/31/2999
M1133	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2020	12/31/2999
M1134	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2020	12/31/2999
M1135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	The start of an episode of care documented in the medical record	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1141	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Functional status was not measured by the oxford knee score (oks) or the knee injury and osteoarthritis outcome score joint replacement (koos, jr.) at one year (9 to 15 months) postoperatively	1/1/2020	12/31/2999
M1142	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergent cases	1/1/2020	12/31/2999
M1143	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Initiated episode of rehabilitation therapy, medical, or chiropractic care for neck impairment	1/1/2020	12/31/2999
M1146	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record	1/1/2021	12/31/2999
M1147	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery	1/1/2021	12/31/2999
M1148	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown)	1/1/2021	12/31/2999
M1149	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient unable to complete the neck fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility, and an adequate proxy is not available	1/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1150	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current or prior left ventricular ejection fraction (lvef) less than or equal to 40% or documentation of moderately or severely depressed left ventricular systolic function	1/1/2023	12/31/2999
M1151	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a history of heart transplant or with a left ventricular assist device (lvad)	1/1/2023	12/31/2999
M1152	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a history of heart transplant or with a left ventricular assist device (lvad)	1/1/2023	12/31/2999
M1153	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient with diagnosis of osteoporosis on date of encounter	1/1/2023	12/31/2999
M1159	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2023	12/31/2999
M1160	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the meningococcal vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1161	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1163	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the hpv vaccine any time on or before the patient's 13th birthday	1/1/2023	12/31/2999
M1164	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with dementia any time during the patient's history through the end of the measurement period	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1165	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who use hospice services any time during the measurement period	1/1/2023	12/31/2999
M1166	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pathology report for tissue specimens produced from wide local excisions or re-excisions	1/1/2023	12/31/2999
M1167	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In hospice or using hospice services during the measurement period	1/1/2023	12/31/2999
M1168	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received an influenza vaccine on or between july 1 of the year prior to the measurement period and june 30 of the measurement period	1/1/2023	12/31/2999
M1169	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine)	1/1/2023	12/31/2999
M1170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive an influenza vaccine on or between july 1 of the year prior to the measurement period and june 30 of the measurement period	1/1/2023	12/31/2999
M1171	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period	1/1/2023	12/31/2999
M1172	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering td or tdap vaccine (e.g., prior anaphylaxis due to the td or tdap vaccine or history of encephalopathy within seven days after a previous dose of a td-containing vaccine)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1173	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period	1/1/2023	12/31/2999
M1174	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received at least two doses of the herpes zoster recombinant vaccine (at least 28 days apart) on october 20, 2017, through the end of the measurement period	1/1/2023	12/31/2999
M1175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine)	1/1/2023	12/31/2999
M1176	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive two doses of the herpes zoster recombinant vaccine (at least 28 days apart) on october 20, 2017, through the end of the measurement period	1/1/2023	12/31/2999
M1177	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2023	12/31/2999
M1178	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine)	1/1/2023	12/31/2999
M1179	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 19th birthday and before or during measurement period	1/1/2023	12/31/2999
M1180	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients on immune checkpoint inhibitor therapy	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1181	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Grade 2 or above diarrhea and/or grade 2 or above colitis	1/1/2023	12/31/2999
M1182	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not eligible due to pre-existing inflammatory bowel disease (ibd) (e.g., ulcerative colitis, crohn's disease)	1/1/2023	12/31/2999
M1183	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered	1/1/2023	12/31/2999
M1184	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing or administering corticosteroid or immunosuppressant treatment (e.g., allergy, intolerance, infectious etiology, pancreatic insufficiency, hyperthyroidism, prior bowel surgical interventions, celiac disease, receiving other medication, awaiting diagnostic workup results for alternative etiologies, other medical reasons/contraindication)	1/1/2023	12/31/2999
M1185	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of immune checkpoint inhibitor therapy not held and/or corticosteroids or immunosuppressants prescribed or administered was not performed, reason not given	1/1/2023	12/31/2999
M1186	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who have an order for or are receiving hospice or palliative care	1/1/2023	12/31/2999
M1187	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of end stage renal disease (esrd)	1/1/2023	12/31/2999
M1188	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of chronic kidney disease (ckd) stage 5	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1189	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a kidney health evaluation defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) performed	1/1/2023	12/31/2999
M1190	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of a kidney health evaluation was not performed or defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr)	1/1/2023	12/31/2999
M1191	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2023	12/31/2999
M1192	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with an existing diagnosis of squamous cell carcinoma of the esophagus	1/1/2023	12/31/2999
M1193	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical pathology reports that contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both	1/1/2023	12/31/2999
M1194	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) surgical pathology reports did not contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both tests were not included (e.g., patient will not be treated with checkpoint inhibitor therapy, no residual carcinoma is present in the sample [tissue exhausted or status post neoadjuvant treatment], insufficient tumor for testing)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1195	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Surgical pathology reports that do not contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both, reason not given	1/1/2023	12/31/2999
M1196	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	1/1/2023	12/31/2999
M1197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	1/1/2023	12/31/2999
M1198	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter	1/1/2023	12/31/2999
M1199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients receiving rrt	1/1/2023	12/31/2999
M1200	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ace inhibitor (ace-i) or arb therapy prescribed during the measurement period	1/1/2023	12/31/2999
M1201	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not prescribing ace inhibitor (ace-i) or arb therapy during the measurement period (e.g., pregnancy, history of angioedema to ace-i, other allergy to ace-i and arb, hyperkalemia or history of hyperkalemia while on ace-i or arb therapy, acute kidney injury due to ace-i or arb therapy), other medical reasons)	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1202	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not prescribing ace inhibitor or arb therapy during the measurement period, (e.g., patient declined, other patient reasons)	1/1/2023	12/31/2999
M1203	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Ace inhibitor or arb therapy not prescribed during the measurement period, reason not given	1/1/2023	12/31/2999
M1204	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4	1/1/2023	12/31/2999
M1205	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score	1/1/2023	12/31/2999
M1206	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter	1/1/2023	12/31/2999
M1207	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	1/1/2023	12/31/2999
M1208	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient is not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	1/1/2023	12/31/2999
M1209	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class, (table 4), without appropriate diagnoses	1/1/2023	12/31/2999
M1210	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	At least two orders for high-risk medications from the same drug class, (table 4), not ordered	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1211	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Most recent glycemic status assessment (hba1c or gmi) level > 9.0%	1/1/2024	12/31/2999
M1212	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glycemic status assessment (hba1c or gmi) level is missing, or was not performed during the measurement period	1/1/2024	12/31/2999
M1213	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No history of spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) and present spirometry is >= 70%	1/1/2024	12/31/2999
M1214	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and reviewed	1/1/2024	12/31/2999
M1215	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of medical reason(s) for not documenting and reviewing spirometry results (e.g., patients with dementia or tracheostomy)	1/1/2024	12/31/2999
M1216	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed with results documented during the encounter	1/1/2024	12/31/2999
M1217	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of system reason(s) for not documenting and reviewing spirometry results (e.g., spirometry equipment not available at the time of the encounter)	1/1/2024	12/31/2999
M1218	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has copd symptoms (e.g., dyspnea, cough/sputum, wheezing)	1/1/2024	12/31/2999
M1220	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; with evidence of retinopathy	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1221	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; without evidence of retinopathy	1/1/2024	12/31/2999
M1222	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glaucoma plan of care not documented, reason not otherwise specified	1/1/2024	12/31/2999
M1223	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Glaucoma plan of care documented	1/1/2024	12/31/2999
M1224	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraocular pressure (iop) reduced by a value less than 20% from the pre-intervention level	1/1/2024	12/31/2999
M1225	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Intraocular pressure (iop) reduced by a value of greater than or equal to 20% from the pre-intervention level	1/1/2024	12/31/2999
M1226	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Iop measurement not documented, reason not otherwise specified	1/1/2024	12/31/2999
M1227	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Evidence-based therapy was prescribed	1/1/2024	12/31/2999
M1228	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, has hcv treatment initiated within 3 months of the reactive hcv antibody test	1/1/2024	12/31/2999
M1229	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, is referred within 1 month of the reactive hcv antibody test to a clinician who treats hcv infection	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1230	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has a reactive hcv antibody test and does not have a follow up hcv viral test, or patient has a reactive hcv antibody test and has a follow up hcv viral test that detects hcv viremia and is not referred to a clinician who treats hcv infection within 1 month and does not have hcv treatment initiated within 3 months of the reactive hcv antibody test, reason not given	1/1/2024	12/31/2999
M1231	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receives hcv antibody test with nonreactive result	1/1/2024	12/31/2999
M1232	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient receives hcv antibody test with reactive result	1/1/2024	12/31/2999
M1233	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient does not receive hcv antibody test or patient does receive hcv antibody test but results not documented, reason not given	1/1/2024	12/31/2999
M1234	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia	1/1/2024	12/31/2999
M1235	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period	1/1/2024	12/31/2999
M1236	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Baseline mrs > 2	1/1/2024	12/31/2999
M1237	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1238	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation that administration of second recombinant zoster vaccine could not occur during the performance period due to the recommended 2-6 month interval between doses (i.e, first dose received after october 31)	1/1/2024	12/31/2999
M1239	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1240	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt this provider and team put my best interests first when making recommendations about my care	1/1/2024	12/31/2999
M1241	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt this provider and team saw me as a person, not just someone with a medical problem	1/1/2024	12/31/2999
M1242	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not respond to the question of patient felt this provider and team understood what is important to me in my life	1/1/2024	12/31/2999
M1243	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient provided a response other than completely true for the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1244	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient provided a response other than completely true for the question of patient felt this provider and team put my best interests first when making recommendations about my care	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1245	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient provided a response other than completely true for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem	1/1/2024	12/31/2999
M1246	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient provided a response other than completely true for the question of patient felt this provider and team understood what is important to me in my life	1/1/2024	12/31/2999
M1247	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded completely true for the question of patient felt this provider and team put my best interests first when making recommendations about my care	1/1/2024	12/31/2999
M1248	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded completely true for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem	1/1/2024	12/31/2999
M1249	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded completely true for the question of patient felt this provider and team understood what is important to me in my life	1/1/2024	12/31/2999
M1250	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient responded as completely true for the question of patient felt heard and understood by this provider and team	1/1/2024	12/31/2999
M1251	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients for whom a proxy completed the entire hu survey on their behalf for any reason (no patient involvement)	1/1/2024	12/31/2999
M1252	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not complete at least one of the four patient experience hu survey items and return the hu survey within 60 days of the ambulatory palliative care visit	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1253	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who respond on the patient experience hu survey that they did not receive care by the listed ambulatory palliative care provider in the last 60 days (disavowal)	1/1/2024	12/31/2999
M1254	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were deceased when the hu survey reached them	1/1/2024	12/31/2999
M1255	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who have another reason for visiting the clinic [not prenatal or postpartum care] and have a positive pregnancy test but have not established the clinic as an ob provider (e.g., plan to terminate the pregnancy or seek prenatal services elsewhere)	1/1/2024	12/31/2999
M1256	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prior history of known cvd	1/1/2024	12/31/2999
M1257	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cvd risk assessment not performed or incomplete (e.g., cvd risk assessment was not documented), reason not otherwise specified	1/1/2024	12/31/2999
M1258	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cvd risk assessment performed, have a documented calculated risk score	1/1/2024	12/31/2999
M1259	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient status documented within the first year of initiating dialysis	1/1/2024	12/31/2999
M1260	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient status not documented within the first year of initiating dialysis	1/1/2024	12/31/2999
M1261	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients that were on the kidney or kidney-pancreas waitlist prior to initiation of dialysis	1/1/2024	12/31/2999
M1262	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a transplant prior to initiation of dialysis	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1263	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients in hospice on their initiation of dialysis date or during the month of evaluation	1/1/2024	12/31/2999
M1265	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cms medical evidence form 2728 for dialysis patients: initial form completed	1/1/2024	12/31/2999
M1266	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients admitted to a skilled nursing facility (snf)	1/1/2024	12/31/2999
M1267	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period	1/1/2024	12/31/2999
M1268	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period	1/1/2024	12/31/2999
M1269	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Receiving esrd mcp dialysis services by the provider on the last day of the reporting month	1/1/2024	12/31/2999
M1270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients not on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period	1/1/2024	12/31/2999
M1271	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with dementia at any time prior to or during the month	1/1/2024	12/31/2999
M1272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients observed on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period	1/1/2024	12/31/2999
M1273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were admitted to a skilled nursing facility (snf) within one year of dialysis initiation according to the cms-2728 form	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were admitted to a skilled nursing facility (snf) during the month of evaluation were excluded from that month	1/1/2024	12/31/2999
M1275	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients determined to be in hospice were excluded from month of evaluation and the remainder of reporting period	1/1/2024	12/31/2999
M1276	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi documented outside normal parameters, no follow-up plan documented, no reason given	1/1/2024	12/31/2999
M1277	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Colorectal cancer screening results documented and reviewed	1/1/2024	12/31/2999
M1278	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented	1/1/2024	12/31/2999
M1279	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given	1/1/2024	12/31/2999
M1280	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy	1/1/2024	12/31/2999
M1281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Blood pressure reading not documented, reason not given	1/1/2024	12/31/2999
M1282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco non-user	1/1/2024	12/31/2999
M1283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and identified as a tobacco user	1/1/2024	12/31/2999
M1284	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients age 66 or older in institutional special needs plans (snp) or residing in long term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	1/1/2024	12/31/2999
M1286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason	1/1/2024	12/31/2999
M1287	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented below normal parameters and a follow-up plan is documented	1/1/2024	12/31/2999
M1288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documented reason for not screening or recommending a follow-up for high blood pressure	1/1/2024	12/31/2999
M1289	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	1/1/2024	12/31/2999
M1290	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not eligible due to active diagnosis of hypertension	1/1/2024	12/31/2999
M1291	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1292	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period	1/1/2024	12/31/2999
M1293	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented above normal parameters and a follow-up plan is documented	1/1/2024	12/31/2999
M1294	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Normal blood pressure reading documented, follow-up not required	1/1/2024	12/31/2999
M1295	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis or past history of total colectomy or colorectal cancer	1/1/2024	12/31/2999
M1296	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi is documented within normal parameters and no follow-up plan is required	1/1/2024	12/31/2999
M1297	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented due to medical reason or patient refusal of height or weight measurement	1/1/2024	12/31/2999
M1298	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter	1/1/2024	12/31/2999
M1299	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza immunization administered or previously received	1/1/2024	12/31/2999
M1300	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)	1/1/2024	12/31/2999
M1302	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Screening, diagnostic, film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	1/1/2024	12/31/2999
M1303	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospice services provided to patient any time during the measurement period	1/1/2024	12/31/2999
M1304	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2024	12/31/2999
M1305	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period	1/1/2024	12/31/2999
M1306	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period	1/1/2024	12/31/2999
M1307	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation stating the patient has received or is currently receiving palliative or hospice care	1/1/2024	12/31/2999
M1308	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Influenza immunization was not administered, reason not given	1/1/2024	12/31/2999
M1309	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Palliative care services provided to patient any time during the measurement period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user	1/1/2024	12/31/2999
M1311	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anaphylaxis due to the vaccine on or before the date of the encounter	1/1/2024	12/31/2999
M1312	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient not screened for tobacco use	1/1/2024	12/31/2999
M1313	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period	1/1/2024	12/31/2999
M1314	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Bmi not documented and no reason is given	1/1/2024	12/31/2999
M1315	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified	1/1/2024	12/31/2999
M1316	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Current tobacco non-user	1/1/2024	12/31/2999
M1317	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are counseled on connection with a csp and explicitly opt out	1/1/2024	12/31/2999
M1318	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening or documentation that there was no contact with a csp	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1319	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening	1/1/2024	12/31/2999
M1320	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who screened positive for at least 1 of the 5 hrsns	1/1/2024	12/31/2999
M1321	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not seen within 7 weeks following the date of injection for follow up or who did not have a documented iop or no plan of care documented if the iop was >25 mm hg	1/1/2024	12/31/2999
M1322	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop =<25 mm hg for injected eye	1/1/2024	12/31/2999
M1323	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop >25 mm hg and a plan of care was documented	1/1/2024	12/31/2999
M1324	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant)	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1325	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not seen for reasons documented by clinician for patient or medical reasons (e.g., inadequate time for follow-up, patients who received a prior intravitreal or periocular steroid injection within the last six (6) months and had a subsequent iop evaluation with iop <25mm hg within seven (7) weeks of treatment)	1/1/2024	12/31/2999
M1326	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of hypotony	1/1/2024	12/31/2999
M1327	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 8 weeks	1/1/2024	12/31/2999
M1328	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a diagnosis of acute vitreous hemorrhage	1/1/2024	12/31/2999
M1329	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 8 weeks after initial acute pvd encounter	1/1/2024	12/31/2999
M1330	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)	1/1/2024	12/31/2999
M1331	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks from initial exam	1/1/2024	12/31/2999
M1332	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 2 weeks	1/1/2024	12/31/2999
M1333	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acute vitreous hemorrhage	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1334	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 2 weeks after initial acute pvd encounter	1/1/2024	12/31/2999
M1335	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)	1/1/2024	12/31/2999
M1336	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks	1/1/2024	12/31/2999
M1337	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Acute pvd	1/1/2024	12/31/2999
M1338	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period	1/1/2024	12/31/2999
M1339	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period	1/1/2024	12/31/2999
M1340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Index assessment completed using the 12-item whodas 2.0 or sds during the denominator identification period	1/1/2024	12/31/2999
M1341	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died during the performance period	1/1/2024	12/31/2999
M1343	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who are at pam level 4 at baseline or patients who are flagged with extreme straight line response sets on the pam or with excessive missing responses	1/1/2024	12/31/2999
M1344	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a baseline pam score and/or a second score within 4 to 12 months of baseline pam score	1/1/2024	12/31/2999
M1345	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a baseline pam score and a second score within 4 to 12 month of baseline pam score	1/1/2024	12/31/2999
M1346	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a net increase in pam score of at least 6 points within a 4 to 12 month period	1/1/2024	12/31/2999
M1347	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who achieved a net increase in pam score of at least 3 points in a 4 to 12 month period (passing)	1/1/2024	12/31/2999
M1348	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who achieved a net increase in pam score of at least 6-points in a 4 to 12 month period (excellent)	1/1/2024	12/31/2999
M1349	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a net increase in pam score of at least 3 points within a 4 to 12 month period	1/1/2024	12/31/2999
M1350	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1351	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a suicide safety plan initiated, reviewed, or updated and reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation	1/1/2024	12/31/2999
M1352	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicidal ideation and/or behavior symptoms based on the c-ssrs or equivalent assessment	1/1/2024	12/31/2999
M1353	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter	1/1/2024	12/31/2999
M1354	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a suicide safety plan initiated, reviewed, or updated or reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation	1/1/2024	12/31/2999
M1355	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicide risk based on their clinician's evaluation or a clinician-rated tool	1/1/2024	12/31/2999
M1356	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died during the measurement period	1/1/2024	12/31/2999
M1357	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who had a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1358	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment	1/1/2024	12/31/2999
M1359	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Index assessment during the denominator period when the suicidal ideation and/or behavior symptoms or increased suicide risk by clinician determination occurs and a non-zero c-ssrs score is obtained	1/1/2024	12/31/2999
M1360	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicidal ideation and/or behavior symptoms based on the c-ssrs	1/1/2024	12/31/2999
M1361	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Suicide risk based on their clinician's evaluation or a clinician-rated tool	1/1/2024	12/31/2999
M1362	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who died during the measurement period	1/1/2024	12/31/2999
M1363	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patients who did not have a follow-up assessment within 120 days of the index assessment	1/1/2024	12/31/2999
M1364	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Calculated 10-year ascvd risk score of >= 20 percent during the performance period	1/1/2024	12/31/2999
M1365	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Patient encounter during the performance period with hospice and palliative care specialty code 17	1/1/2024	12/31/2999
M1366	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Focusing on women's health mips value pathway	1/1/2024	12/31/2999
M1367	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Quality care for the treatment of ear, nose, and throat disorders mips value pathway	1/1/2024	12/31/2999
M1368	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Prevention and treatment of infectious disorders including hepatitis c and hiv mips value pathway	1/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
M1369	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Quality care in mental health and substance use disorders mips value pathway	1/1/2024	12/31/2999
M1370	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Rehabilitative support for musculoskeletal care mips value pathway	1/1/2024	12/31/2999
P2031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Hair analysis (excluding arsenic)	1/1/2013	12/31/2999
P9020	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Platelet rich plasma, each unit	12/1/2020	12/31/2999
P9099	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Blood component or product not otherwise classified	1/1/2020	12/31/2999
P9603	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled	1/1/2013	12/31/2999
P9604	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge.	1/1/2013	12/31/2999
P9615	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Catheterization for collection of specimen (s) (multiple patients)	1/1/2013	12/31/2999
Q0092	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Set-up portable x-ray equipment	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0224	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to COVID-19 vaccination, 4500 mg	3/22/2024	12/31/2999
Q0477	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2018	12/31/2999
Q0478	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type	1/1/2013	12/31/2999
Q0479	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power module for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0480	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Driver for use with pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0481	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control unit for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0482	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0483	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor/display module for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0484	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0485	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor control cable for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0486	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0487	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0488	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power pack base for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0489	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power pack base for use with electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0490	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power source for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0491	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0492	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power supply cable for use with electric ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0493	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0494	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0495	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0496	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0497	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0498	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0499	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0500	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0501	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only	5/1/2015	12/31/2999
Q0502	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Mobility cart for pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0503	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery for pneumatic ventricular assist device, replacement only, each	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0504	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	1/1/2013	12/31/2999
Q0506	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only	1/1/2013	12/31/2999
Q0507	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0507	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0508	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0508	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	4/1/2013	12/31/2999
Q0509	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	4/1/2013	12/31/2999
Q0509	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	4/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q0510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH FOLLOWING transPLANT	1/1/2013	12/31/2999
Q0511	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD	1/1/2013	12/31/2999
Q0512	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	5/16/2016	12/31/2999
Q0513	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 30 DAYS	1/1/2013	12/31/2999
Q0514	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 90 DAYS	1/1/2013	12/31/2999
Q0515	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, SERMORELIN ACETATE, 1 MICROGRAM	1/1/2013	12/31/2999
Q0521	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription	1/1/2025	12/31/2999
Q2026	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INJECTION, RADIESSE, 0.1 ML	1/1/2013	12/31/2999
Q2028	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, sculptra, 0.5 mg	1/1/2014	12/31/2999
Q2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Influenza virus vaccine, not otherwise specified	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2041	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	4/1/2018	12/31/2999
Q2042	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	1/1/2019	12/31/2999
Q2049	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg	4/1/2024	12/31/2999
Q2050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg	10/24/2019	12/31/2999
Q2052	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig)	4/1/2014	12/31/2999
Q2053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	4/1/2021	12/31/2999
Q2054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	10/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q2055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	1/1/2022	12/31/2999
Q2056	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	10/1/2022	12/31/2999
Q3014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telehealth originating site facility fee	1/1/2021	12/31/2999
Q4050	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Cast supplies, for unlisted types and materials of casts	1/1/1950	12/31/2999
Q4051	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)	1/1/1950	12/31/2999
Q4082	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	1/1/2007	12/31/2999
Q4101	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Apligraf, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Oasis wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4103	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oasis burn matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4104	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Integra bilayer matrix wound dressing (bmwd), per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4105	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Graftjacket, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Integra matrix, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4110	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Primatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4111	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Gammagraft, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4112	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	CYMETRA, INJECTABLE, 1CC	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4113	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	GRAFTJACKET XPRESS, INJECTABLE, 1CC	5/15/2021	12/31/2999
Q4114	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC	8/1/2019	12/31/2999
Q4115	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4116	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alloderm, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hyalomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4118	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MATRISTEM MICROMATRIX, 1 MG	5/15/2021	12/31/2999
Q4121	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Theraskin, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Dermacell, dermacell awm or dermacell awm porous, per square centimeter (add-on, list separately in addition to primary procedure)	10/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4123	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloskin rt, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4124	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Oasis ultra tri-layer wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4125	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroflex, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4126	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4127	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Talymed, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flex hd, or allopatch hd, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2019	12/31/2999
Q4130	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Strattice tm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4132	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix core and grafixpl core, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4133	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2018	12/31/2999
Q4134	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Hmatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4135	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Mediskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4136	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ez-derm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4137	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter (add-on, list separately in addition to primary procedure)	8/1/2024	12/31/2999
Q4138	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence dryflex, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4139	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniomatrix or biodmatrix, injectable, 1 cc	12/1/2020	12/31/2999
Q4140	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Biodfence, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4158	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Kerecis omega3, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Affinity, per square centimeter (add-on, list separately in addition to primary procedure)	2/1/2022	12/31/2999
Q4160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nushield, per square centimeter (add-on, list separately in addition to primary procedure)	12/15/2025	12/31/2999
Q4161	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bio-connekt wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4162	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex flow, bioskin flow, 0.5 cc	12/1/2020	12/31/2999
Q4163	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundex, bioskin, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4164	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Helicoll, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4165	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Keramatrix or kerasorb, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4166	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cytal, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4167	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Truskin, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4168	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioband, 1 mg	8/1/2018	12/31/2999
Q4169	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent wound, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4170	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4171	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Interfyl, 1 mg	12/1/2020	12/31/2999
Q4173	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen or palingen xplus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4174	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen or promatrx, 0.36 mg per 0.25 cc	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4175	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Miroderm, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2021	12/31/2999
Q4176	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neopatch or therion, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4177	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Floweramnioflo, 0.1 cc	12/1/2020	12/31/2999
Q4178	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Floweramniopatch, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4179	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Flowerderm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4180	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Revita, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4181	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio wound, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4182	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Transcyte, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4183	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4184	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta or cellesta duo, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4185	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	12/1/2020	12/31/2999
Q4186	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epifix, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2019	12/31/2999
Q4187	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Epicord, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2019	12/31/2999
Q4188	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioarmor, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4189	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac, 1 mg	12/1/2020	12/31/2999
Q4190	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent ac, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4208	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Novafix, per square cenitmeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4209	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4211	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnion bio or axobiomembrane, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4212	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Allogen, per cc	12/1/2020	12/31/2999
Q4213	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ascent, 0.5 mg	12/1/2020	12/31/2999
Q4214	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cellesta cord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4215	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl ambient or axolotl cryo, 0.1 mg	12/1/2020	12/31/2999
Q4216	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent cord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4217	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundfix, biowound, woundfix plus, biowound plus, woundfix xplus or biowound xplus, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4218	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgicord, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4219	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgigraft-dual, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4220	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Bellacell hd or surederm, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4221	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniowrap2, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4222	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Progenamatrix, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2021	12/31/2999
Q4224	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Human health factor 10 amniotic patch (hhf10-p), per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4225	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniobind or dermabind tl, per square centimeter (add-on, list separately in addition to primary procedure)	4/1/2022	12/31/2999
Q4226	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	MyOwn skin, includes harvesting and preparation procedures, per square centimeter	10/1/2024	12/31/2999
Q4227	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4229	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4230	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cogenex flowable amnion, per 0.5 cc	12/1/2020	12/31/2999
Q4232	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Corplex, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999
Q4233	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surfactor or nudyn, per 0.5 cc	12/1/2020	12/31/2999
Q4234	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcellerate, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2020	12/31/2999

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

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

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4261	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Tag, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4262	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dual layer impax membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4263	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft tl, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4264	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cocoon membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2023	12/31/2999
Q4265	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim tl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4266	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4267	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Neostim dl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4268	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4269	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Surgraft xt, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4270	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete sl, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4271	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Complete ft, per square centimeter (add-on, list separately in addition to primary procedure)	9/1/2023	12/31/2999
Q4272	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano a, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4273	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aaa, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4274	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano ac, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4275	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Esano aca, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4276	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Orion, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4278	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epieffect, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4279	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vendaje ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4280	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xcell amnio matrix, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4281	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Barrera sl or barrera dl, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4282	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus dual, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4283	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Biovance tri-layer or biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2023	12/31/2999
Q4284	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind sl, per square centimeter (add-on, list separately in addition to primary procedure)	12/1/2023	12/31/2999
Q4285	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Nudyn dl or nudyn dl mesh, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2023	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4294	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio quad-core, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4295	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio tri-core amniotic, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4296	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Rebound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4297	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Emerge matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4298	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore pro, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4299	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore pro+, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4300	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso tl, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4301	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Activate matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4310	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Procenta, per 100 mg	4/1/2024	12/31/2999
Q4311	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4312	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acesso ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4313	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dermabind fm, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4314	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Reeva ft, per square cenitmeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4315	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Regenelink amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4316	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amchoplast, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4317	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vitograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4318	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	E-graft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4319	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Sanograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4320	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Pellograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4321	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Renograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4322	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Caregraft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4323	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Alloply, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4324	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniotx, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4325	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Acapatch, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4326	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Woundplus, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4327	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Duoamnion, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4328	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Most, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4329	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Singlay, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4330	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Total, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4331	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl graft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4332	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Axolotl dualgraft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999
Q4333	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Ardeograft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4334	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 1, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4335	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnioplast 2, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4336	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent c, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4337	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent trident, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4338	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent velos, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4339	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Artacent vericlen, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4340	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simpligraft, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999
Q4341	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Simplimax, per square centimeter (add-on, list separately in addition to primary procedure)	5/15/2025	12/31/2999

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4350	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palisade dm matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4351	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Enclose tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4352	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Overlay sl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4353	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xceed tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	6/15/2025	12/31/2999
Q4354	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Palingen dual-layer membrane and dual-layer palingen x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4355	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4356	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Abiomend membrane and abiomend hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4357	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap plus, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4358	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Xwrap dual, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4359	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Choriply, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4360	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amchoplast fd, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4361	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Epixpress, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4362	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Cygnus disk, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4363	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon membrane and hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4364	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4365	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amnio burgeon dual-layer membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4366	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Dual layer amnio burgeon x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4367	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Amniocore sl, per square centimeter (add-on, list separately in addition to primary procedure)	9/15/2025	12/31/2999
Q4368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchothick, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4369	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioplast 3, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4370	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Aeroguard, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4371	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neoguard, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4372	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchoplast excel, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4373	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Membrane wrap lite, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4375	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Duograft ac, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4376	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Duograft aa, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4377	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Trigraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4378	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Renew ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4379	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniodefend ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4380	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Advograft one, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4382	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Advograft dual, per square centimeter (add-on, list separately in addition to primary procedure)	7/1/2025	12/31/2999
Q4383	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axolotl graft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4384	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Axolotl dualgraft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4385	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Apollo ft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4386	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Acesso trifaca, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4387	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium ft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4388	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium 4l, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4389	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Neothelium 4l+, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4390	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ascendion, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4391	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amnioplast double, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4392	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Grafix duo, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4393	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgraft ac, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4394	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surgraft aca, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4395	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Acelagraft, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4396	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Natalin, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999
Q4397	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit aaa, per square centimeter (add-on, list separately in addition to primary procedure)	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4398	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit ac, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4399	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Summit fx, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Polygon3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Absolv3 membrane, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap 2.0, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap dual plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4404	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap hydro plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap fenestra plus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4406	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap fenestra, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4407	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap tribus, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4408	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Xwrap hydro, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4409	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniomatrixf3x, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4410	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amchomatrixdl, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniomatrixf4x, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4412	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Choriofix, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4413	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cygnus solo, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4414	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Simplichor, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4415	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard sl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4416	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard tl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4417	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Alexiguard dl-t, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q4420	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nuform, per square centimeter (add-on, list separately in addition to primary procedure)	1/1/2026	12/31/2999
Q4431	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pma skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4431	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Pma skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4432	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4432	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	510(k) skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4433	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q4433	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure)	1/1/2026	12/31/2999
Q5009	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (NOS)	1/1/2007	12/31/2999
Q5010	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	HOSPICE HOME CARE PROVIDED IN A HOSPICE FACILITY	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q5101	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram	10/1/2021	12/31/2999
Q5108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg	10/1/2021	12/31/2999
Q5110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram	10/1/2021	12/31/2999
Q5120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg	10/1/2021	12/31/2999
Q5122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	10/1/2021	12/31/2999
Q5124	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	4/1/2022	12/31/2999
Q5128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	6/1/2023	12/31/2999
Q5136	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	6/1/2025	12/31/2999
Q5146	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	1/1/2025	12/31/2999
Q5147	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	4/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
Q5149	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	4/1/2025	12/31/2999
Q5150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	4/1/2025	12/31/2999
Q5153	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	7/1/2025	12/31/2999
Q5155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5157	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5158	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5159	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	10/1/2025	12/31/2999
Q5160	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	1/1/2026	3/31/2026
Q9001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assessment by chaplain services	10/1/2020	12/31/2999
Q9002	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Counseling, individual, by chaplain services	10/1/2020	12/31/2999
Q9003	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Counseling, group, by chaplain services	10/1/2020	12/31/2999
Q9004	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Department of veterans affairs whole health partner services	10/1/2021	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
R0070	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen	1/1/2013	12/31/2999
R0075	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen	1/1/2013	12/31/2999
R0076	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation of portable ekg to facility or location, per patient	1/1/2013	12/31/2999
S0126	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, follitropin alfa, 75 iu	1/1/2013	12/31/2999
S0128	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Injection, follitropin beta, 75 iu	1/1/2013	12/31/2999
S0132	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Injection, ganirelix acetate, 250 mcg	1/1/2018	12/31/2999
S0155	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sterile dilutant for epoprostenol, 50ml	1/1/2013	12/31/2999
S0197	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PRENATAL VITAMINS, 30-DAY SUPPLY	1/1/2013	12/31/2999
S0207	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport	8/1/2016	12/31/2999
S0208	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Paramedic intercept, hospital-based als service (non-voluntary), non-transport	8/1/2016	12/31/2999
S0209	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Wheelchair van, mileage, per mile	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0215	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Non-emergency transportation; mileage, per mile	1/1/2013	12/31/2999
S0260	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service)	1/1/2013	12/31/2999
S0271	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PHYSICIAN MANAGEMENT OF PATIENT HOME CARE, HOSPICE MONTHLY CASE RATE (PER 30 DAYS)	1/1/2013	12/31/2999
S0302	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service)	1/1/2013	12/31/2999
S0310	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hospitalist services (list separately in addition to code for appropriate evaluation and management service)	1/1/2013	12/31/2999
S0340	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter / stage	1/1/2013	12/31/2999
S0341	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter / stage	1/1/2013	12/31/2999
S0342	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lifestyle modification program for management of coronary artery disease, including all supportive services; fourth quarter / stage	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S0395	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic	1/1/2014	12/31/2999
S0510	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Non-prescription lens (safety, athletic, or sunglass), per lens	1/1/2022	12/31/2999
S0516	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Safety eyeglass frames	1/1/2022	12/31/2999
S0518	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sunglasses frames	1/1/2022	12/31/2999
S0590	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Integral lens service, miscellaneous services reported separately	1/1/1950	12/31/2999
S0596	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR	1/1/2013	12/31/2999
S0800	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laser in situ keratomileusis (lasik)	1/1/2013	12/31/2999
S0810	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Photorefractive keratectomy (prk)	1/1/2021	12/31/2999
S0812	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Phototherapeutic keratectomy (ptk)	1/1/2013	12/31/2999
S1001	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Deluxe item, patient aware (list in addition to code for basic item)	1/1/1950	12/31/2999
S1001	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Deluxe item, patient aware (list in addition to code for basic item)	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S1002	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Customized item (list in addition to code for basic item)	1/1/1950	12/31/2999
S1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use cpt code)	1/1/2013	12/31/2999
S1031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use cpt code)	1/1/2013	12/31/2999
S1034	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Artificial pancreas device system (eg, low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices	7/1/2014	12/31/2999
S1035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Sensor; invasive (eg, subcutaneous), disposable, for use with artificial pancreas device system, 1 unit = 1 day supply	7/1/2014	12/31/2999
S1036	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transmitter; external, for use with artificial pancreas device system	7/1/2014	12/31/2999
S1037	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Receiver (monitor); external, for use with artificial pancreas device system	7/1/2014	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S1040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT(S)	1/1/2013	12/31/2999
S1091	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Stent, non-coronary, temporary, with delivery system (propel)	4/1/2021	12/31/2999
S2053	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation of small intestine and liver allografts	11/1/2016	12/31/2999
S2054	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transplantation of multivisceral organs	11/1/2016	12/31/2999
S2055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor	11/1/2016	12/31/2999
S2060	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Lobar lung transplantation	1/1/2013	12/31/2999
S2061	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Donor lobectomy (lung) for transplantation, living donor	1/1/2013	12/31/2999
S2065	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Simultaneous pancreas kidney transplantation	1/1/2013	12/31/2999
S2066	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BREAST RECONSTRUCTION WITH GLUTEAL ARTERY PERFORATOR (GAP) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL	6/15/2024	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2067	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BREAST RECONSTRUCTION OF A SINGLE BREAST WITH "STACKED" DEPP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP(S) AND/OR GLUTEAL ARTERY PERFORATOR (GAP) FLAP(S), INCLUDING HARVESTING OF THE FLAP(S), MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE(S) AND SHAPING TH	6/15/2024	12/31/2999
S2068	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	BREAST RECONSTRUCTION WITH DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP OR SUPERFICIAL INFERIOR EPIGASTRIC ARTERY (SIEA) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERA	6/15/2024	12/31/2999
S2080	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Laser-assisted uvulopalatoplasty (laup)	1/1/2013	12/31/2999
S2083	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	1/1/2013	12/31/2999
S2095	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	1/1/2013	12/31/2999
S2102	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Islet cell tissue transplant from pancreas; allogeneic	9/1/2020	12/31/2999
S2107	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Adoptive immunotherapy i. E. Development of specific anti-tumor reactivity (e. G. Tumor-infiltrating lymphocyte therapy) per course of treatment	9/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2112	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	1/1/2013	12/31/2999
S2117	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Arthroereisis, subtalar	12/1/2020	12/31/2999
S2118	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Metal-on-metal total hip resurfacing, including acetabular and femoral components	1/1/2013	12/31/2999
S2120	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Low density lipoprotein (ldl) apheresis using heparin-induced extracorporeal ldl precipitation	1/1/2013	12/31/2999
S2140	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood harvesting for transplantation, allogeneic	1/1/2013	12/31/2999
S2142	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Cord blood-derived stem-cell transplantation, allogeneic	1/1/2013	12/31/2999
S2150	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2152	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor (s), procurement, transplantation, and related complications; including: 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	9/1/2016	12/31/2999
S2202	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Echosclerotherapy	1/1/2013	12/31/2999
S2348	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, USING RADIOFREQUENCY ENERGY, SINGLE OR MULTIPLE LEVELS, LUMBAR	4/1/2020	12/31/2999
S2400	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero	9/1/2020	12/31/2999
S2401	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, urinary tract obstruction in the fetus, procedure performed in utero	1/1/2013	12/31/2999
S2402	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero	1/1/2013	12/31/2999
S2403	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S2404	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, myelomeningocele in the fetus, procedure performed in utero	1/1/2013	12/31/2999
S2405	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	1/1/2013	12/31/2999
S2409	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	1/1/2013	12/31/2999
S2409	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified	10/24/2019	12/31/2999
S2411	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome	3/1/2020	12/31/2999
S3601	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility	1/1/2013	12/31/2999
S3650	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test, hormone level; during menopause	12/1/2020	12/31/2999
S3652	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Saliva test, hormone level; to assess preterm labor risk	12/1/2020	12/31/2999
S3900	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Surface electromyography (emg)	10/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S4011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development	11/1/2015	12/31/2999
S4013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete cycle, gamete intrafallopian transfer (gift), case rate	11/1/2015	12/31/2999
S4014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete cycle, zygote intrafallopian transfer (zift), case rate	11/1/2015	12/31/2999
S4015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Complete in vitro fertilization cycle, not otherwise specified, case rate	10/24/2019	12/31/2999
S4015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Complete in vitro fertilization cycle, not otherwise specified, case rate	11/1/2015	12/31/2999
S4016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Frozen in vitro fertilization cycle, case rate	11/1/2015	12/31/2999
S4017	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incomplete cycle, treatment cancelled prior to stimulation, case rate	1/1/2013	12/31/2999
S4018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Frozen embryo transfer procedure cancelled before transfer, case rate	1/1/2013	12/31/2999
S4020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In vitro fertilization procedure cancelled before aspiration, case rate	1/1/2013	12/31/2999
S4021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	In vitro fertilization procedure cancelled after aspiration, case rate	1/1/2013	12/31/2999
S4022	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted oocyte fertilization, case rate	11/1/2015	12/31/2999
S4023	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Donor egg cycle, incomplete, case rate	1/1/2013	12/31/2999
S4025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Donor services for in vitro fertilization (sperm or embryo), case rate	11/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S4026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Procurement of donor sperm from sperm bank	11/1/2015	12/31/2999
S4027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Storage of previously frozen embryos	11/1/2015	12/31/2999
S4028	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Microsurgical epididymal sperm aspiration (mesa)	1/1/2013	12/31/2999
S4030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; initial visit	11/1/2015	12/31/2999
S4031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sperm procurement and cryopreservation services; subsequent visit	11/1/2015	12/31/2999
S4037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Cryopreserved embryo transfer, case rate	11/1/2015	12/31/2999
S4040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Monitoring and storage of cryopreserved embryos, per 30 days	11/1/2015	12/31/2999
S4042	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	MANAGEMENT OF OVULATION INDUCTION (INTERPRETATION OF DIAGNOSTIC TESTS AND STUDIES, NON-FACE-TO-FACE MEDICAL MANAGEMENT OF THE PATIENT), PER CYCLE	1/1/2013	12/31/2999
S4990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, legend	1/1/2022	12/31/2999
S4991	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Nicotine patches, non-legend	1/1/2022	12/31/2999
S5100	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per 15 minutes	1/1/2023	12/31/2999
S5101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per half day	1/1/2023	12/31/2999
S5102	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, adult; per diem	1/1/2023	12/31/2999
S5105	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day care services, center-based; services not included in program fee, per diem	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5108	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home care training to home care client, per 15 minutes	5/1/2021	12/31/2999
S5110	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home care training, family; per 15 minutes	5/1/2021	12/31/2999
S5111	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home care training, family; per session	5/1/2021	12/31/2999
S5120	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per 15 minutes	1/1/2023	12/31/2999
S5121	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Chore services; per diem	1/1/2023	12/31/2999
S5130	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per 15 minutes	1/1/1950	12/31/2999
S5130	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per 15 minutes	1/1/2023	12/31/2999
S5131	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Homemaker service, nos; per diem	1/1/1950	12/31/2999
S5131	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Homemaker service, nos; per diem	1/1/2023	12/31/2999
S5135	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per 15 minutes	1/1/2023	12/31/2999
S5136	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Companion care, adult (e. G. Iadl/adl); per diem	1/1/2023	12/31/2999
S5140	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per diem	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S5141	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, adult; per month	1/1/2023	12/31/2999
S5145	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per diem	1/1/2023	12/31/2999
S5146	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Foster care, therapeutic, child; per month	1/1/2023	12/31/2999
S5162	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Emergency response system; purchase only	1/1/2022	12/31/2999
S5165	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home modifications; per service	1/1/2013	12/31/2999
S5170	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Home delivered meals, including preparation; per meal	1/1/2023	12/31/2999
S5175	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Laundry service, external, professional; per order	1/1/2023	12/31/2999
S5181	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home health respiratory therapy, nos, per diem	10/24/2019	12/31/2999
S5199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Personal care item, nos, each	1/1/1950	12/31/2999
S5199	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Personal care item, nos, each	1/1/2023	12/31/2999
S5497	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S8035	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Magnetic source imaging	1/1/2013	12/31/2999
S8040	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Topographic brain mapping	1/1/2013	12/31/2999
S8130	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	2/15/2015	12/31/2999
S8131	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	2/15/2015	12/31/2999
S8185	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Flutter device	1/1/2013	12/31/2999
S8189	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Tracheostomy supply, not otherwise classified	1/1/1950	12/31/2999
S8270	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Enuresis alarm, using auditory buzzer and/or vibration device	1/1/2013	12/31/2999
S8301	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Infection control supplies, not otherwise specified	1/1/1950	12/31/2999
S8301	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Infection control supplies, not otherwise specified	1/1/2013	12/31/2999
S8990	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Physical or manipulative therapy performed for maintenance rather than restoration	1/1/2020	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9024	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Paranasal sinus ultrasound	9/1/2020	12/31/2999
S9055	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Procuren or other growth factor preparation to promote wound healing	9/1/2020	12/31/2999
S9090	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	Vertebral axial decompression, per session	2/15/2015	12/31/2999
S9122	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home health aide or certified nurse assistant, providing care in the home; per hour	1/1/2021	12/31/2999
S9123	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when cpt codes 99500-99602 can be used)	11/1/2016	12/31/2999
S9124	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nursing care, in the home; by licensed practical nurse, per hour	11/1/2016	12/31/2999
S9128	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Speech therapy, in the home, per diem	1/1/2013	12/31/2999
S9129	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Occupational therapy, in the home, per diem	6/1/2015	12/31/2999
S9131	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Physical therapy; in the home, per diem	6/1/2015	12/31/2999
S9145	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Insulin pump initiation, instruction in initial use of pump (pump not included)	12/1/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9340	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9341	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9342	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9343	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9355	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9364	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes s9365-s9368 using daily volume scales)	1/1/2013	12/31/2999
S9365	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9366	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9367	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9368	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home infusion therapy, total parenteral nutrition (tpn); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9379	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/1950	12/31/2999
S9381	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Delivery or service to high risk areas requiring escort or extra protection, per visit	1/1/2013	12/31/2999
S9430	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Pharmacy compounding and dispensing services	11/1/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9432	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Medical foods for non-inborn errors of metabolism	10/1/2021	12/31/2999
S9433	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	MEDICAL FOOD NUTRITIONALLY COMPLETE, ADMINISTERED ORALLY, PROVIDING 100% OF NUTRITIONAL INTAKE	1/1/2013	12/31/2999
S9445	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, individual, per session	1/1/1950	12/31/2999
S9446	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Patient education, not otherwise classified, non-physician provider, group, per session	1/1/1950	12/31/2999
S9449	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Weight management classes, non-physician provider, per session	1/1/2013	12/31/2999
S9537	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; hematopoietic hormone injection therapy (e. G. Erythropoietin, g-csf, gm-csf); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9542	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	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	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9542	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	10/24/2019	12/31/2999
S9558	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9560	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home injectable therapy; hormonal therapy (e. G. ; leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	1/1/2013	12/31/2999
S9810	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	1/1/2013	12/31/2999
S9810	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9960	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	1/1/2014	12/31/2999
S9961	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	1/1/2014	12/31/2999
S9975	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transplant related lodging, meals and transportation, per diem	5/1/2015	12/31/2999
S9976	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Lodging, per diem, not otherwise classified	1/1/1950	12/31/2999
S9976	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging, per diem, not otherwise classified	1/1/2021	12/31/2999
S9977	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Meals, per diem, not otherwise specified	1/1/1950	12/31/2999
S9977	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals, per diem, not otherwise specified	1/1/2021	12/31/2999
S9988	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services provided as part of a phase i clinical trial	1/1/2013	12/31/2999
S9990	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services provided as part of a phase ii clinical trial	1/1/2013	12/31/2999
S9991	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Services provided as part of a phase iii clinical trial	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
S9992	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion	1/1/2013	12/31/2999
S9994	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion	1/1/2013	12/31/2999
S9996	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Meals for clinical trial participant and one caregiver/companion	1/1/2013	12/31/2999
S9999	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Sales tax	1/1/2013	12/31/2999
T1000	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Private duty / independent nursing service(s) - licensed, up to 15 minutes	1/1/2013	12/31/2999
T1014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Telehealth transmission, per minute, professional services bill separately	1/1/2021	12/31/2999
T1030	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nursing care, in the home, by registered nurse, per diem	3/1/2021	12/31/2999
T1031	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Nursing care, in the home, by licensed practical nurse, per diem	3/1/2021	12/31/2999
T1032	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by a doula birth worker, per 15 minutes	10/1/2022	12/31/2999
T1033	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Services performed by a doula birth worker, per diem	10/1/2022	12/31/2999
T1040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medicaid certified community behavioral health clinic services, per diem	1/1/2017	12/31/2999
T1041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Medicaid certified community behavioral health clinic services, per month	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T1505	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	ELECTRONIC MEDICATION COMPLIANCE MANAGEMENT DEVICE, INCLUDES ALL COMPONENTS AND ACCESSORIES, NOT OTHERWISE CLASSIFIED	10/24/2019	12/31/2999
T1999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks	10/24/2019	12/31/2999
T2012	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational; waiver, per diem	7/1/2008	12/31/2999
T2012	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, educational; waiver, per diem	1/1/2023	12/31/2999
T2013	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, educational, waiver; per hour	7/1/2008	12/31/2999
T2013	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, educational, waiver; per hour	1/1/2023	12/31/2999
T2014	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per diem	7/1/2008	12/31/2999
T2014	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, prevocational, waiver; per diem	1/1/2023	12/31/2999
T2015	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, prevocational, waiver; per hour	7/1/2008	12/31/2999
T2015	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, prevocational, waiver; per hour	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2016	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; per diem	7/1/2008	12/31/2999
T2016	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, residential, waiver; per diem	1/1/2023	12/31/2999
T2017	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, residential, waiver; 15 minutes	7/1/2008	12/31/2999
T2017	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, residential, waiver; 15 minutes	1/1/2023	12/31/2999
T2018	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per diem	7/1/2008	12/31/2999
T2018	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, supported employment, waiver; per diem	1/1/2023	12/31/2999
T2019	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Habilitation, supported employment, waiver; per 15 minutes	7/1/2008	12/31/2999
T2019	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, supported employment, waiver; per 15 minutes	1/1/2023	12/31/2999
T2020	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per diem	7/1/2008	12/31/2999
T2020	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day habilitation, waiver; per diem	1/1/2023	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2021	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Day habilitation, waiver; per 15 minutes	7/1/2008	12/31/2999
T2021	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Day habilitation, waiver; per 15 minutes	1/1/2023	12/31/2999
T2024	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Service assessment/plan of care development, waiver	7/1/2008	12/31/2999
T2025	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Waiver services; not otherwise specified (nos)	7/1/2008	12/31/2999
T2026	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per diem	7/1/2008	12/31/2999
T2026	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized childcare, waiver; per diem	1/1/2023	12/31/2999
T2027	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized childcare, waiver; per 15 minutes	7/1/2008	12/31/2999
T2027	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Specialized childcare, waiver; per 15 minutes	1/1/2023	12/31/2999
T2028	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized supply, not otherwise specified, waiver	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2029	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Specialized medical equipment, not otherwise specified, waiver	10/24/2019	12/31/2999
T2030	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living, waiver; per month	7/1/2008	12/31/2999
T2030	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted living, waiver; per month	1/1/2023	12/31/2999
T2031	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assisted living; waiver, per diem	7/1/2008	12/31/2999
T2031	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assisted living; waiver, per diem	1/1/2023	12/31/2999
T2032	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per month	7/1/2008	12/31/2999
T2033	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Residential care, not otherwise specified (nos), waiver; per diem	7/1/2008	12/31/2999
T2034	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Crisis intervention, waiver; per diem	7/1/2008	12/31/2999
T2035	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Utility services to support medical equipment and assistive technology/devices, waiver	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2035	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Utility services to support medical equipment and assistive technology/devices, waiver	1/1/2023	12/31/2999
T2036	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, overnight, waiver; each session	7/1/2008	12/31/2999
T2036	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic camping, overnight, waiver; each session	1/1/2023	12/31/2999
T2037	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Therapeutic camping, day, waiver; each session	7/1/2008	12/31/2999
T2037	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Therapeutic camping, day, waiver; each session	1/1/2023	12/31/2999
T2038	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Community transition, waiver; per service	7/1/2008	12/31/2999
T2038	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Community transition, waiver; per service	1/1/2023	12/31/2999
T2039	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vehicle modifications, waiver; per service	7/1/2008	12/31/2999
T2039	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Vehicle modifications, waiver; per service	1/1/2023	12/31/2999
T2040	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Financial management, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T2040	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Financial management, self-directed, waiver; per 15 minutes	1/1/2023	12/31/2999
T2041	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supports brokerage, self-directed, waiver; per 15 minutes	7/1/2008	12/31/2999
T2041	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supports brokerage, self-directed, waiver; per 15 minutes	1/1/2023	12/31/2999
T2047	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Habilitation, prevocational, waiver; per 15 minutes	10/1/2020	12/31/2999
T2050	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Financial management, self-directed, waiver; per diem	4/1/2022	12/31/2999
T2051	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Supports brokerage, self-directed, waiver; per diem	4/1/2022	12/31/2999
T2101	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Human breast milk processing, storage and distribution only	2/1/2020	12/31/2999
T4521	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH	1/1/2025	12/31/2999
T4522	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH	1/1/2025	12/31/2999
T4523	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH	1/1/2025	12/31/2999
T4524	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH	1/1/2025	12/31/2999
T4525	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH	1/1/2025	12/31/2999
T4526	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH	1/1/2025	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T4527	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	1/1/2025	12/31/2999
T4528	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH	1/1/2025	12/31/2999
T4529	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH	1/1/2025	12/31/2999
T4530	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH	1/1/2025	12/31/2999
T4531	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH	1/1/2025	12/31/2999
T4532	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	1/1/2025	12/31/2999
T4533	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	1/1/2025	12/31/2999
T4534	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	1/1/2025	12/31/2999
T4535	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH	1/1/2025	12/31/2999
T4536	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, REUSABLE, ANY SIZE, EACH	1/1/2017	12/31/2999
T4537	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, BED SIZE, EACH	1/1/2017	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
T4538	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DIAPER SERVICE, REUSABLE DIAPER, EACH DIAPER	1/1/2017	12/31/2999
T4539	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DIAPER/BRIEF, REUSABLE, ANY SIZE, EACH	1/1/2017	12/31/2999
T4540	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH	1/1/2017	12/31/2999
T4541	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH	1/1/2017	12/31/2999
T4542	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, SMALL SIZE, EACH	1/1/2017	12/31/2999
T4543	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each	1/1/2017	12/31/2999
T4544	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each	1/1/2014	12/31/2999
T4545	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Incontinence product, disposable, penile wrap, each	1/1/2019	12/31/2999
T5999	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Supply, not otherwise specified	7/1/2008	12/31/2999
V2025	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Deluxe frame	1/1/2020	12/31/2999
V2199	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Not otherwise classified, single vision lens	10/24/2019	12/31/2999
V2599	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Contact lens, other type	10/24/2019	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2600	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Hand held low vision aids and other nonspectacle mounted aids	1/1/2022	12/31/2999
V2629	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Prosthetic eye, other type	1/1/1950	12/31/2999
V2702	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	DELUXE LENS FEATURE	1/1/2020	12/31/2999
V2744	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Tint, photochromatic, per lens	1/1/2022	12/31/2999
V2745	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	1/1/2022	12/31/2999
V2750	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Anti-reflective coating, per lens	1/1/2018	12/31/2999
V2755	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	U-v lens, per lens	1/1/2018	12/31/2999
V2756	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Eye glass case	1/1/2022	12/31/2999
V2760	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Scratch resistant coating, per lens	1/1/2022	12/31/2999
V2761	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Mirror coating, any type, solid, gradient or equal, any lens material, per lens	1/1/2022	12/31/2999
V2762	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Polarization, any lens material, per lens	1/1/2022	12/31/2999
V2787	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	1/1/2013	12/31/2999
V2788	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V2790	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Amniotic membrane for surgical reconstruction, per procedure	5/1/2020	12/31/2999
V2799	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review.	Vision item or service, miscellaneous	5/15/2018	12/31/2999
V2799	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Vision item or service, miscellaneous	10/24/2019	12/31/2999
V5011	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Fitting/orientation/checking of hearing aid	1/1/2021	12/31/2999
V5090	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Dispensing fee, unspecified hearing aid	10/24/2019	12/31/2999
V5267	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	1/1/1950	12/31/2999
V5268	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, telephone amplifier, any type	1/1/2013	12/31/2999
V5269	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, alerting, any type	3/15/2015	12/31/2999
V5271	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, television caption decoder	3/15/2015	12/31/2999
V5272	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, tdd	3/15/2015	12/31/2999
V5273	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, for use with cochlear implant	3/15/2015	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V5274	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, not otherwise specified	1/1/1950	12/31/2999
V5274	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, not otherwise specified	3/15/2015	12/31/2999
V5281	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type	1/1/2013	12/31/2999
V5282	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm system, binaural, (2 receivers, transmitter, microphone), any type	1/1/2013	12/31/2999
V5283	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm neck, loop induction receiver	1/1/2013	12/31/2999
V5284	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm, ear level receiver	1/1/2013	12/31/2999
V5285	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm, direct audio input receiver	1/1/2013	12/31/2999
V5286	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal blue tooth fm/dm receiver	1/1/2013	12/31/2999
V5287	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Assistive listening device, personal fm/dm receiver, not otherwise specified	10/24/2019	12/31/2999
V5288	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm transmitter assistive listening device	1/1/2013	12/31/2999
V5289	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, personal fm/dm adapter/boot coupling device for receiver, any type	1/1/2013	12/31/2999
V5290	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Assistive listening device, transmitter microphone, any type	1/1/2013	12/31/2999

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date
V5298	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing aid, not otherwise classified	1/1/1950	12/31/2999
V5299	Unlisted: Procedure/service not specifically defined or classified, maybe subject to contract/clinical review. Prior Authorization may be required per contract agreement.	Hearing service, miscellaneous	1/1/1950	12/31/2999
V5336	Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review.	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)	1/1/2013	12/31/2999

CPT copyright 2025 American Medical Association. All rights reserved. CPT is a registered trademark of the AMA.

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

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

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

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