BlueCross BlueShield of Texas

# 2025 Recommended Clinical Review, Post-Service Review and Non-Covered Procedure Code List - Administrative Services Only (ASO)
## Effective 1/1/2025 through 1/1/2026
## (Updated January 2025)

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| **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:**<br>**- Subject to a medical necessity review,**<br>**- Candidates for a Recommended Clinical Review,**<br>**- Not a benefit for our members,**<br>**- Considered experimental, investigational and unproven, or**<br>**- Not on our prior authorization list (with some exceptions based on members' benefit plans) Except as otherwise noted in the date column, these codes are effective on or before January 1, 2025** | **Utilization Management Process**<br><br>**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 |
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| Medical Policy Criteria (MP Criteria) | Procedures/services reviewed against Medical Policy criteria. Submit for Recommended Clinical Review to avoid post-service review.<br>Highlighted procedure/service in this code group may require Prior Authorization per contract agreement. |
| Rotary Wing & Ground Ambulance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. Managed by Alacura. |
| Non Covered | Procedures/services not covered by the Plan. Not subject to pre-service review. |
| Experimental, Investigational, Unproven | Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policies. |
| 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 | | Ending Date |
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| 640 | Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 797 | Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11200 | Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 11201 | Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 11950 | Subcutaneous injection of filling material (eg, collagen); 1 cc or less | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11951 | Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11952 | Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11954 | Subcutaneous injection of filling material (eg, collagen); over 10.0 cc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11960 | Insertion of tissue expander(s) for other than breast, including subsequent expansion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2006 | 12/31/2999 |
| 11970 | Replacement of tissue expander with permanent implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2006 | 12/31/2999 |
| 11980 | Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 11981 | Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007 | 9/14/2024 |
| 11983 | Removal with reinsertion, non-biodegradable drug delivery implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007 | 9/14/2024 |
| 15271 | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15272 | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15273 | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15274 | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15275 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |

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| 15276 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15277 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15278 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| 15758 | Free fascial flap with microvascular anastomosis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2010 | 12/31/2999 |
| 15769 | Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2021 | 12/31/2999 |
| 15771 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2021 | 12/31/2999 |
| 15772 | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2021 | 12/31/2999 |
| 15775 | Punch graft for hair transplant; 1 to 15 punch grafts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15776 | Punch graft for hair transplant; more than 15 punch grafts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15780 | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005 | 12/31/2999 |
| 15781 | Dermabrasion; segmental, face | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005 | 12/31/2999 |
| 15782 | Dermabrasion; regional, other than face | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15783 | Dermabrasion; superficial, any site (eg, tattoo removal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15786 | Abrasion; single lesion (eg, keratosis, scar) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005 | 12/31/2999 |
| 15787 | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2005 | 12/31/2999 |
| 15788 | Chemical peel, facial; epidermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15789 | Chemical peel, facial; dermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15792 | Chemical peel, nonfacial; epidermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 15793 | Chemical peel, nonfacial; dermal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15819 | Cervicoplasty | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 15820 | Blepharoplasty, lower eyelid; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15821 | Blepharoplasty, lower eyelid; with extensive herniated fat pad | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15822 | Blepharoplasty, upper eyelid; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15823 | Blepharoplasty, upper eyelid; with excessive skin weighting down lid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 15824 | Rhytidectomy; forehead | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 9/14/2024 |
| 15825 | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15826 | Rhytidectomy; glabellar frown lines | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 9/14/2024 |
| 15828 | Rhytidectomy; cheek, chin, and neck | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15829 | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15830 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 15832 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15833 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15834 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15835 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15836 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15837 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15838 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15839 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 15876 | Suction assisted lipectomy; head and neck | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15877 | Suction assisted lipectomy; trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 15878 | Suction assisted lipectomy; upper extremity | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |

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| 15879 | Suction assisted lipectomy; lower extremity | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 17106 | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 17107 | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 17108 | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 17340 | Cryotherapy (CO2 slush, liquid N2) for acne | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 17340 | Cryotherapy (CO2 slush, liquid N2) for acne | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 17360 | Chemical exfoliation for acne (eg, acne paste, acid) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 17380 | Electrolysis epilation, each 30 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 19105 | Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 19300 | Mastectomy for gynecomastia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 19303 | Mastectomy, simple, complete | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 19316 | Mastopexy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 4/14/2024 |
| 19318 | Breast reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 19325 | Breast augmentation with implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19328 | Removal of intact breast implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19330 | Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19340 | Insertion of breast implant on same day of mastectomy (ie, immediate) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19342 | Insertion or replacement of breast implant on separate day from mastectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2005 | 12/31/2999 |
| 19350 | Nipple/areola reconstruction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 19355 | Correction of inverted nipples | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19357 | Tissue expander placement in breast reconstruction, including subsequent expansion(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 19370 | Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19371 | Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 19499 | Unlisted procedure, breast | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |

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| 20527 | Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| 20560 | Needle insertion(s) without injection(s); 1 or 2 muscle(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 20560 | Needle insertion(s) without injection(s); 1 or 2 muscle(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 20561 | Needle insertion(s) without injection(s); 3 or more muscles | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 20561 | Needle insertion(s) without injection(s); 3 or more muscles | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 20979 | Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 20982 | Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2007 | 12/31/2999 |
| 20983 | Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2020 | 12/31/2999 |
| 20985 | Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 20985 | Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 21032 | Excision of maxillary torus palatinus | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 21073 | Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2013 | 12/31/2999 |
| 21083 | Impression and custom preparation; palatal lift prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| 21120 | Genioplasty; augmentation (autograft, allograft, prosthetic material) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 21121 | Genioplasty; sliding osteotomy, single piece | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 21122 | Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 21123 | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 21244 | Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 21245 | Reconstruction of mandible or maxilla, subperiosteal implant; partial | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 21246 | Reconstruction of mandible or maxilla, subperiosteal implant; complete | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 21248 | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 21249 | Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 21685 | Hyoid myotomy and suspension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 22505 | Manipulation of spine requiring anesthesia, any region | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 22526 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22526 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22527 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22527 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22586 | Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 22586 | Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 22836 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22836 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22836 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 22837 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22837 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22837 | Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |

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| 22838 | Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22838 | Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 22838 | Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 22867 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22867 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22868 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22868 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22869 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22869 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22870 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 22870 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 23929 | Unlisted procedure, shoulder | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |
| 24300 | Manipulation, elbow, under anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2013 | 12/31/2999 |

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| 25259 | Manipulation, wrist, under anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2013 | 12/31/2999 |
| 26340 | Manipulation, finger joint, under anesthesia, each joint | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2013 | 12/31/2999 |
| 26341 | Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| 27275 | Manipulation, hip joint, requiring general anesthesia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2015 | 12/31/2999 |
| 27278 | Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 27278 | Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 27278 | Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 27299 | Unlisted procedure, pelvis or hip joint | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 27702 | Arthroplasty, ankle; with implant (total ankle) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2009 | 12/31/2999 |
| 27703 | Arthroplasty, ankle; revision, total ankle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2015 | 12/31/2999 |
| 27860 | Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2013 | 12/31/2999 |
| 28890 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 28890 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 29862 | Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| 29866 | Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s]) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 29867 | Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2007 | 12/31/2999 |
| 29868 | Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| 29914 | Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| 29915 | Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |

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| 29916 | Arthroscopy, hip, surgical; with labral repair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| 29999 | Unlisted procedure, arthroscopy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |
| 30468 | Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 30468 | Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 30469 | Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 30469 | Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 31242 | Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 31242 | Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 31242 | Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 31243 | Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 31243 | Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 31243 | Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 31647 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 31648 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 31649 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 31651 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s]) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 31660 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |

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| 31661 | Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 32994 | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| 32998 | Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2007 | 12/31/2999 |
| 33211 | Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 33213 | Insertion of pacemaker pulse generator only; with existing dual leads | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 33225 | Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2006 | 12/31/2999 |
| 33267 | Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 33268 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 33269 | Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 33274 | Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 33276 | Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33276 | Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33276 | Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33277 | Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |

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| 33277 | Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33277 | Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33278 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33278 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33278 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33279 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33279 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33279 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33280 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33280 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33280 | Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33281 | Repositioning of phrenic nerve stimulator transvenous lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33281 | Repositioning of phrenic nerve stimulator transvenous lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33281 | Repositioning of phrenic nerve stimulator transvenous lead(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33285 | Insertion, subcutaneous cardiac rhythm monitor, including programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |

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| 33287 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33287 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33287 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33288 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33288 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 33288 | Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 33289 | Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| 33361 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 33362 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 33363 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015 | 12/31/2999 |
| 33364 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015 | 12/31/2999 |
| 33365 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2015 | 12/31/2999 |
| 33366 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| 33367 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 33368 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |

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| 33369 | Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 33418 | Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016 | 12/31/2999 |
| 33419 | Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016 | 12/31/2999 |
| 33477 | Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| 33927 | Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| 33928 | Removal and replacement of total replacement heart system (artificial heart) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| 33999 | Unlisted procedure, cardiac surgery | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |
| 36465 | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| 36466 | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| 36468 | Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 36470 | Injection of sclerosant; single incompetent vein (other than telangiectasia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 36471 | Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 36473 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 36473 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 36474 | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 36474 | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 36475 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 36476 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 36478 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 36479 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 36482 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019 | 12/31/2999 |
| 36483 | Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2019 | 12/31/2999 |
| 36522 | Photopheresis, extracorporeal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 36836 | Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 36836 | Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |

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| 36837 | Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 36837 | Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 37215 | Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2006 | 12/31/2999 |
| 37216 | Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 37217 | Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2014 | 12/31/2999 |
| 37218 | Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| 37241 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| 37242 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| 37243 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| 37244 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |

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| 37500 | Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37700 | Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37718 | Ligation, division, and stripping, short saphenous vein | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37722 | Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37735 | Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37760 | Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37761 | Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2010 | 12/31/2999 |
| 37765 | Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37766 | Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37780 | Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37785 | Ligation, division, and/or excision of varicose vein cluster(s), 1 leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2006 | 12/31/2999 |
| 37790 | Penile venous occlusive procedure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2007 | 12/31/2999 |
| 38204 | Management of recipient hematopoietic progenitor cell donor search and cell acquisition | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38205 | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38206 | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 1/31/2024 |
| 38207 | Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38208 | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38209 | Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38210 | Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38211 | Transplant preparation of hematopoietic progenitor cells; tumor cell depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38212 | Transplant preparation of hematopoietic progenitor cells; red blood cell removal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38213 | Transplant preparation of hematopoietic progenitor cells; platelet depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38214 | Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38215 | Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 38230 | Bone marrow harvesting for transplantation; allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 1/31/2024 |
| 38232 | Bone marrow harvesting for transplantation; autologous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| 38240 | Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38241 | Hematopoietic progenitor cell (HPC); autologous transplantation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 1/31/2024 |
| 38242 | Allogeneic lymphocyte infusions | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 38243 | Hematopoietic progenitor cell (HPC); HPC boost | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 38308 | Lymphangiotomy or other operations on lymphatic channels | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2014 | 12/31/2999 |
| 41120 | Glossectomy; less than one-half tongue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 41512 | Tongue base suspension, permanent suture technique | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| 41530 | Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 3/31/2024 |
| 41530 | Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 3/31/2024 |
| 41530 | Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| 41872 | Gingivoplasty, each quadrant (specify) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 12/31/2999 |
| 42140 | Uvulectomy, excision of uvula | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| 42145 | Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 42950 | Pharyngoplasty (plastic or reconstructive operation on pharynx) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 43206 | Esophagoscopy, flexible, transoral; with optical endomicroscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 43206 | Esophagoscopy, flexible, transoral; with optical endomicroscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 43210 | Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2016 | 12/31/2999 |
| 43236 | Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 43252 | Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 43252 | Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 43257 | Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2010 | 12/31/2999 |
| 43284 | Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2017 | 12/31/2999 |
| 43289 | Unlisted laparoscopy procedure, esophagus | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 43290 | Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 43290 | Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 43291 | Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 43291 | Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 43632 | Gastrectomy, partial, distal; with gastrojejunostomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2023 | 12/31/2999 |
| 43633 | Gastrectomy, partial, distal; with Roux-en-Y reconstruction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2007 | 12/31/2999 |
| 43644 | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 43645 | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 43770 | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43771 | Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43772 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43773 | Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43774 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43775 | Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2010 | 12/31/2999 |

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| 43842 | Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 43843 | Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 43845 | Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2009 | 12/31/2999 |
| 43846 | Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 43847 | Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 43848 | Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 43886 | Gastric restrictive procedure, open; revision of subcutaneous port component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43887 | Gastric restrictive procedure, open; removal of subcutaneous port component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 43888 | Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 44705 | Preparation of fecal microbiota for instillation, including assessment of donor specimen | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| 46707 | Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 46707 | Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 47370 | Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 47371 | Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 47380 | Ablation, open, of 1 or more liver tumor(s); radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 47382 | Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 47383 | Ablation, 1 or more liver tumor(s), percutaneous, cryoablation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 50250 | Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2008 | 12/31/2999 |
| 50360 | Renal allotransplantation, implantation of graft; without recipient nephrectomy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2016 | 12/31/2999 |
| 50541 | Laparoscopy, surgical; ablation of renal cysts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2005 | 12/31/2999 |
| 50542 | Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 50592 | Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 50593 | Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2008 | 12/31/2999 |
| 51715 | Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2007 | 12/31/2999 |
| 52284 | Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 52284 | Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 52284 | Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 52327 | Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| 52441 | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| 52442 | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| 53451 | Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53451 | Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53451 | Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 9/30/2024 |
| 53452 | Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53452 | Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53452 | Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 9/30/2024 |
| 53453 | Periurethral transperineal adjustable balloon continence device; removal, each balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53453 | Periurethral transperineal adjustable balloon continence device; removal, each balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |

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| 53453 | Periurethral transperineal adjustable balloon continence device; removal, each balloon | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 9/30/2024 |
| 53454 | Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53454 | Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 53454 | Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 9/30/2024 |
| 53855 | Insertion of a temporary prostatic urethral stent, including urethral measurement | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 53855 | Insertion of a temporary prostatic urethral stent, including urethral measurement | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 53855 | Insertion of a temporary prostatic urethral stent, including urethral measurement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2020 | 5/14/2024 |
| 53860 | Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 53860 | Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 54125 | Amputation of penis; complete | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 54200 | Injection procedure for Peyronie disease; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2010 | 12/31/2999 |
| 54205 | Injection procedure for Peyronie disease; with surgical exposure of plaque | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2010 | 12/31/2999 |
| 54240 | Penile plethysmography | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 54400 | Insertion of penile prosthesis; non-inflatable (semi-rigid) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54401 | Insertion of penile prosthesis; inflatable (self-contained) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54405 | Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54406 | Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54408 | Repair of component(s) of a multi-component, inflatable penile prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54410 | Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54411 | Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| 54415 | Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54416 | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54417 | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 54660 | Insertion of testicular prosthesis (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 55706 | Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2013 | 12/31/2999 |
| 55873 | Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2007 | 12/31/2999 |
| 55880 | Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2021 | 12/31/2999 |
| 55899 | Unlisted procedure, male genital system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |
| 55970 | Intersex surgery; male to female | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 55980 | Intersex surgery; female to male | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 56805 | Clitoroplasty for intersex state | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 56810 | Perineoplasty, repair of perineum, nonobstetrical (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2008 | 12/31/2999 |
| 57291 | Construction of artificial vagina; without graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 57292 | Construction of artificial vagina; with graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 57296 | Revision (including removal) of prosthetic vaginal graft; open abdominal approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| 57335 | Vaginoplasty for intersex state | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2006 | 12/31/2999 |
| 57426 | Revision (including removal) of prosthetic vaginal graft, laparoscopic approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2010 | 12/31/2999 |
| 58321 | Artificial insemination; intra-cervical | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58322 | Artificial insemination; intra-uterine | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58323 | Sperm washing for artificial insemination | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 58580 | Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 58750 | Tubotubal anastomosis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/15/2008 | 12/31/2999 |

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| 59072 | Fetal umbilical cord occlusion, including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| 59074 | Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2022 | 12/31/2999 |
| 59076 | Fetal shunt placement, including ultrasound guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| 60699 | Unlisted procedure, endocrine system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 61630 | Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 61630 | Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 61635 | Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 61645 | Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| 61736 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2022 | 12/31/2999 |
| 61737 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2022 | 12/31/2999 |
| 61783 | Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 61783 | Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 61783 | Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 6/30/2024 |
| 61889 | Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 61891 | Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 61892 | Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |

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| 62263 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 62263 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 62264 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 62264 | Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 62287 | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 62287 | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 64555 | Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2017 | 12/31/2999 |
| 64555 | Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| 64566 | Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 64568 | Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| 64575 | Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| 64582 | Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2022 | 3/14/2024 |
| 64590 | Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |

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| 64596 | Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 64597 | Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 64624 | Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 |
| 64628 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 64628 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 64629 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 64629 | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| 64640 | Destruction by neurolytic agent; other peripheral nerve or branch | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |
| 64809 | Sympathectomy, thoracolumbar | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/19/2014 | 12/31/2999 |
| 65760 | Keratomileusis | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| 65767 | Epikeratoplasty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 65770 | Keratoprosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 65772 | Corneal relaxing incision for correction of surgically induced astigmatism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| 65775 | Corneal wedge resection for correction of surgically induced astigmatism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| 65785 | Implantation of intrastromal corneal ring segments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| 66174 | Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2012 | 12/31/2999 |
| 66175 | Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2012 | 12/31/2999 |
| 66179 | Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| 66180 | Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2021 | 12/31/2999 |
| 66183 | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |

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| 66989 | Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2022 | 12/31/2999 |
| 66991 | Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2022 | 12/31/2999 |
| 67028 | Intravitreal injection of a pharmacologic agent (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 1/31/2024 |
| 67516 | Suprachoroidal space injection of pharmacologic agent (separate procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 67900 | Repair of brow ptosis (supraciliary, mid-forehead or coronal approach) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 2/14/2024 |
| 67901 | Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 67902 | Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 67903 | Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 67904 | Repair of blepharoptosis; (tarso) levator resection or advancement, external approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 67906 | Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 67908 | Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 69090 | Ear piercing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2020 | 12/31/2999 |
| 69300 | Otoplasty, protruding ear, with or without size reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 69705 | Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2021 | 12/31/2999 |
| 69706 | Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/15/2021 | 12/31/2999 |
| 69716 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2022 | 12/31/2999 |

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| 69719 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2022 | 12/31/2999 |
| 69728 | Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 69729 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 69730 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 76120 | Cineradiography/videoradiography, except where specifically included | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| 76125 | Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| 76940 | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| 82523 | Collagen cross links, any method | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| 82523 | Collagen cross links, any method | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| 83695 | Lipoprotein (a) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83695 | Lipoprotein (a) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83698 | Lipoprotein-associated phospholipase A2 (Lp-PLA2) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83698 | Lipoprotein-associated phospholipase A2 (Lp-PLA2) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83701 | Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 83701 | Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83704 | Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83704 | Lipoprotein, blood; quantitation of lipoprotein particle number(s) (eg, by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83722 | Lipoprotein, direct measurement; small dense LDL cholesterol | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83722 | Lipoprotein, direct measurement; small dense LDL cholesterol | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83937 | Osteocalcin (bone g1a protein) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83937 | Osteocalcin (bone g1a protein) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 83987 | pH; exhaled breath condensate | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 83987 | pH; exhaled breath condensate | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 84112 | Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 84112 | Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 84431 | Thromboxane metabolite(s), including thromboxane if performed, urine | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 84431 | Thromboxane metabolite(s), including thromboxane if performed, urine | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 86001 | Allergen specific IgG quantitative or semiquantitative, each allergen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 86001 | Allergen specific IgG quantitative or semiquantitative, each allergen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 86328 | 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]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86328 | 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]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86343 | Leukocyte histamine release test (LHR) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 86343 | Leukocyte histamine release test (LHR) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 86353 | Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 86408 | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86408 | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); screen | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86409 | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86409 | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]); titer | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86413 | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86413 | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) antibody, quantitative | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86769 | Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86769 | Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 86910 | Blood typing, for paternity testing, per individual; ABO, Rh and MN | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 86911 | Blood typing, for paternity testing, per individual; each additional antigen system | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 87505 | Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2020 | 12/31/2999 |

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| 87506 | Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2020 | 12/31/2999 |
| 87507 | Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2020 | 12/31/2999 |
| 88000 | Necropsy (autopsy), gross examination only; without CNS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88005 | Necropsy (autopsy), gross examination only; with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88007 | Necropsy (autopsy), gross examination only; with brain and spinal cord | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88012 | Necropsy (autopsy), gross examination only; infant with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88014 | Necropsy (autopsy), gross examination only; stillborn or newborn with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88016 | Necropsy (autopsy), gross examination only; macerated stillborn | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88020 | Necropsy (autopsy), gross and microscopic; without CNS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88025 | Necropsy (autopsy), gross and microscopic; with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88027 | Necropsy (autopsy), gross and microscopic; with brain and spinal cord | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88028 | Necropsy (autopsy), gross and microscopic; infant with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88029 | Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88036 | Necropsy (autopsy), limited, gross and/or microscopic; regional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88037 | Necropsy (autopsy), limited, gross and/or microscopic; single organ | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88040 | Necropsy (autopsy); forensic examination | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88045 | Necropsy (autopsy); coroner's call | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88099 | Unlisted necropsy (autopsy) procedure | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 88375 | Optical endomicroscopic image(s), interpretation and report, real time or referred, each endoscopic session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 88375 | Optical endomicroscopic image(s), interpretation and report, real time or referred, each endoscopic session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 89258 | Cryopreservation; embryo(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |

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| 89259 | Cryopreservation; sperm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| 89335 | Cryopreservation, reproductive tissue, testicular | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89337 | Cryopreservation, mature oocyte(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2019 | 12/31/2999 |
| 89342 | Storage (per year); embryo(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89343 | Storage (per year); sperm/semen | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89344 | Storage (per year); reproductive tissue, testicular/ovarian | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 89346 | Storage (per year); oocyte(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89352 | Thawing of cryopreserved; embryo(s) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89353 | Thawing of cryopreserved; sperm/semen, each aliquot | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 3/20/2018 | 12/31/2999 |
| 89354 | Thawing of cryopreserved; reproductive tissue, testicular/ovarian | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 89356 | Thawing of cryopreserved; oocytes, each aliquot | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 90378 | Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 90666 | Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2010 | 12/31/2999 |
| 90667 | Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2010 | 12/31/2999 |
| 90668 | Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2010 | 12/31/2999 |
| 90683 | Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 5/31/2024 |
| 90867 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90868 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90869 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| 90875 | Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 90876 | Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| 90880 | Hypnotherapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 5/31/2024 |

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| 90885 | Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 90889 | Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 90901 | Biofeedback training by any modality | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 90912 | Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021 | 12/31/2999 |
| 90913 | Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021 | 12/31/2999 |
| 91065 | Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 91065 | Breath hydrogen or methane test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 91110 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 91111 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 91111 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 91112 | Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91112 | Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91113 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 91113 | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 91117 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |

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| 91132 | Electrogastrography, diagnostic, transcutaneous; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91132 | Electrogastrography, diagnostic, transcutaneous; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91133 | Electrogastrography, diagnostic, transcutaneous; with provocative testing | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 91133 | Electrogastrography, diagnostic, transcutaneous; with provocative testing | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 92065 | Orthoptic training; performed by a physician or other qualified health care professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 11/1/2013 | 12/31/2999 |
| 92132 | Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 92132 | Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 92145 | Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92145 | Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92512 | Nasal function studies (eg, rhinomanometry) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 92512 | Nasal function studies (eg, rhinomanometry) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 92517 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 92517 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 92518 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 92518 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 92519 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 92519 | Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| 92548 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92548 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92549 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92549 | Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 92622 | Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 92623 | Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 92972 | Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 93050 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 93050 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 93150 | Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93150 | Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93150 | Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 93151 | Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |

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| 93151 | Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93151 | Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 93152 | Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93152 | Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93152 | Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 93153 | Interrogation without programming of implanted phrenic nerve stimulator system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93153 | Interrogation without programming of implanted phrenic nerve stimulator system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 93153 | Interrogation without programming of implanted phrenic nerve stimulator system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 93228 | External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 93229 | External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2020 | 12/31/2999 |
| 93264 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 93580 | Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2005 | 12/31/2999 |

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| 93660 | Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 93702 | Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 93702 | Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 93740 | Temperature gradient studies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 93740 | Temperature gradient studies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94014 | Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94014 | Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94015 | Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94015 | Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94016 | Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94016 | Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 94452 | High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 94453 | High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 95060 | Ophthalmic mucous membrane tests | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 95060 | Ophthalmic mucous membrane tests | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 95065 | Direct nasal mucous membrane test | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 95065 | Direct nasal mucous membrane test | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 95700 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95705 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95706 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95707 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95708 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95709 | Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95710 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95711 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95712 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95713 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95714 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95715 | Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |

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| 95716 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95717 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95718 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95719 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95720 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95721 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95722 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95723 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95724 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95725 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |

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| 95726 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95803 | Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 95803 | Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 95803 | Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 9/30/2024 |
| 95905 | Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 95905 | Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 95919 | Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 95919 | Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 95954 | Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95957 | Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2023 | 12/31/2999 |
| 95961 | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| 95962 | Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| 95965 | Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| 95966 | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |

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| 95967 | Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| 95981 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| 95982 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| 96000 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010 | 12/31/2999 |
| 96001 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010 | 12/31/2999 |
| 96002 | Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010 | 12/31/2999 |
| 96003 | Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010 | 12/31/2999 |
| 96004 | Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2010 | 12/31/2999 |
| 96547 | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 96548 | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 96571 | Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| 96912 | Photochemotherapy; psoralens and ultraviolet A (PUVA) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2009 | 12/31/2999 |
| 96913 | Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2010 | 12/31/2999 |

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| 97037 | Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| 97545 | Work hardening/conditioning; initial 2 hours | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 97546 | Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 97610 | Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 97610 | Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 97810 | Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 97811 | Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 97813 | Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 97814 | Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| 98978 | Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 2/29/2024 |
| 99026 | Hospital mandated on call service; in-hospital, each hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99027 | Hospital mandated on call service; out-of-hospital, each hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99071 | Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99075 | Medical testimony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99080 | Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99082 | Unusual travel (eg, transportation and escort of patient) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99175 | Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| 99360 | Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99450 | Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with chain of custody protocols; and Completion of necessary documentation/certificates. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99455 | Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99456 | Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| 99509 | Home visit for assistance with activities of daily living and personal care | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| 0052U | Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2018 | 12/31/2999 |
| 0052U | Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2018 | 12/31/2999 |
| 0054T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0054T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0055T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 0055T | Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0062U | Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0062U | Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0063U | Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0063U | Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0071T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 |
| 0072T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2023 | 12/31/2999 |
| 0075T | Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2006 | 12/31/2999 |
| 0076T | Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2006 | 12/31/2999 |
| 0100T | Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0100T | Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 9/14/2024 |
| 0101T | Extracorporeal shock wave involving musculoskeletal system, not otherwise specified | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0101T | Extracorporeal shock wave involving musculoskeletal system, not otherwise specified | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0102T | Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0102T | Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 0105U | Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2024 | 12/31/2999 |
| 0106T | Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0106T | Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0106U | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0106U | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0107T | Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0107T | Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0108T | Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0108T | Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0109T | Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0109T | Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0110T | Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0110T | Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0198T | Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 0198T | Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0200T | Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0201T | Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0202T | Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0202T | Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0207T | Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0207T | Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0219T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0219T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0220T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0220T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0221T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0221T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0222T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 0222T | Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0224U | Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 0224U | Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 0226U | Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 0226U | Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, seru | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| 0232T | Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0232T | Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0253T | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| 0263T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0263T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0264T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0264T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0265T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 0265T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0266T | Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0267T | Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0268T | Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019 | 12/31/2999 |
| 0269T | Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0270T | Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0271T | Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0272T | Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019 | 12/31/2999 |
| 0273T | Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0274T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |

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| 0274T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0275T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0275T | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0278T | Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0278T | Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0308T | Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2012 | 12/31/2999 |
| 0312U | Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| 0322U | Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | 12/31/2999 |
| 0322U | Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | 12/31/2999 |

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| 0322U | Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 1/14/2024 |
| 0330T | Tear film imaging, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0330T | Tear film imaging, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0331T | Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021 | 12/31/2999 |
| 0332T | Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019 | 12/31/2999 |
| 0335T | Insertion of sinus tarsi implant | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0335T | Insertion of sinus tarsi implant | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0338T | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0338T | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0339T | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0339T | Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 0345T | Transcatheter mitral valve repair percutaneous approach via the coronary sinus | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2016 | 12/31/2999 |
| 0347T | Placement of interstitial device(s) in bone for radiostereometric analysis (RSA) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0347T | Placement of interstitial device(s) in bone for radiostereometric analysis (RSA) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0348T | Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0348T | Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0349T | Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0349T | Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0350T | Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0350T | Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0352T | Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real-time or referred | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0354T | Optical coherence tomography of breast, surgical cavity; interpretation and report, real-time or referred | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0358T | Bioelectrical impedance analysis whole body composition assessment, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0358T | Bioelectrical impedance analysis whole body composition assessment, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0369U | Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 0369U | Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 0369U | Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 5/14/2024 |

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| 0378T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0378T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0379T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0379T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0397T | Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0397T | Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0398T | Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2020 | 12/31/2999 |
| 0402T | Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2017 | 12/31/2999 |
| 0407U | Nephrology (diabetic chronic kidney disease [CKD]), multiplex electrochemiluminescent immunoassay (ECLIA) of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) combined with clinical data, plasma, algorithm reported as risk for progressive decline in kidney function | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2024 | 12/31/2999 |
| 0408T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |

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| 0409T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0410T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0411T | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0412T | Removal of permanent cardiac contractility modulation system; pulse generator only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0413T | Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0414T | Removal and replacement of permanent cardiac contractility modulation system pulse generator only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0415T | Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0416T | Relocation of skin pocket for implanted cardiac contractility modulation pulse generator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0417T | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0418T | Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0422T | Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0440T | Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 0441T | Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 0442T | Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 0449T | Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2020 | 12/31/2999 |
| 0450T | Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2021 | 12/31/2999 |
| 0464T | Visual evoked potential, testing for glaucoma, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 0464T | Visual evoked potential, testing for glaucoma, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0472T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0472T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 9/14/2024 |
| 0473T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0473T | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 9/14/2024 |
| 0474T | Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2017 | 12/31/2999 |
| 0479T | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0480T | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| 0483T | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0484T | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0485T | Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0485T | Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0486T | Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 0486T | Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0494T | Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0495T | Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0496T | Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| 0507T | Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0507T | Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0509T | Electroretinography (ERG) with interpretation and report, pattern (PERG) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 0509T | Electroretinography (ERG) with interpretation and report, pattern (PERG) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 0511T | Removal and reinsertion of sinus tarsi implant | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0511T | Removal and reinsertion of sinus tarsi implant | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0512T | Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0512T | Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |

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| 0513T | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0513T | 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) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| 0516T | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 0517T | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 0524T | Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 0529T | Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| 0537T | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0538T | Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0539T | Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0540T | Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0544T | Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| 0545T | Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0546T | Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2024 | 12/31/2999 |
| 0552T | Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/15/2020 | 12/31/2999 |
| 0563T | Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| 0563T | Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| 0565T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0565T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0566T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0566T | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0569T | Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0570T | Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0587T | Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| 0588T | Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| 0589T | Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| 0590T | Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| 0596T | Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |
| 0597T | Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |

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| 0598T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0598T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0598T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2024 | 9/30/2024 |
| 0599T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0599T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0599T | Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2024 | 9/30/2024 |
| 0600T | Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0601T | Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0602T | Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |
| 0602T | Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |
| 0603T | Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |
| 0603T | Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |
| 0615T | Eye-movement analysis without spatial calibration, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 0615T | Eye-movement analysis without spatial calibration, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| 0619T | Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| 0619T | Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0619T | Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| 0620T | Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0620T | Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0621T | Trabeculostomy ab interno by laser; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0621T | Trabeculostomy ab interno by laser; | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0622T | Trabeculostomy ab interno by laser; with use of ophthalmic endoscope | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0622T | Trabeculostomy ab interno by laser; with use of ophthalmic endoscope | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0623T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0623T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0624T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |

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| 0624T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0625T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0625T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0626T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0626T | Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0627T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0627T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0628T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0628T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0629T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0629T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0630T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |

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| 0630T | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0631T | Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0631T | Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0632T | Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0639T | Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0639T | Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2021 | 12/31/2999 |
| 0640T | Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0640T | Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0643T | Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| 0645T | Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| 0646T | Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| 0650T | Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |

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| 0651T | Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0651T | Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0656T | Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0656T | Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0657T | Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0657T | Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2021 | 12/31/2999 |
| 0664T | Donor hysterectomy (including cold preservation); open, from cadaver donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0664T | Donor hysterectomy (including cold preservation); open, from cadaver donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0665T | Donor hysterectomy (including cold preservation); open, from living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0665T | Donor hysterectomy (including cold preservation); open, from living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0666T | Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0666T | Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0667T | Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0667T | Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0668T | Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0668T | Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |

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| 0669T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0669T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0670T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0670T | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| 0672T | Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0672T | Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0692T | Therapeutic ultrafiltration | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| 0720T | Percutaneous electrical nerve field stimulation, cranial nerves, without implantation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2024 | 12/31/2999 |
| 0740T | Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0741T | Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2023 | 12/31/2999 |
| 0743T | Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0743T | Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0744T | Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0744T | Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

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| 0745T | Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0746T | Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0747T | Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0748T | Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0748T | Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0764T | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0765T | Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2023 | 12/31/2999 |
| 0766T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0766T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0767T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0767T | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0770T | Virtual reality technology to assist therapy (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

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| 0770T | Virtual reality technology to assist therapy (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0771T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0771T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0772T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0772T | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0773T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0773T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

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| 0774T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0774T | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0776T | Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0776T | Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0777T | Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0777T | Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0778T | Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0778T | Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0779T | Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0779T | Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0780T | Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| 0781T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

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| 0781T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0782T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0782T | Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| 0783T | Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0783T | Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| 0784T | Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0785T | Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0786T | Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0787T | Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0788T | Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0789T | Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0790T | Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| 0790T | Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |

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| 0790T | Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| 0791T | Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0791T | Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0793T | Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0795T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0796T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0797T | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0798T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0799T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |

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| 0800T | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0801T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0802T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0803T | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0804T | Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0805T | Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0806T | Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0807T | Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0807T | Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |

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| 0808T | Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0808T | Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2023 | 12/31/2999 |
| 0810T | Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| 0811T | Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 0812T | Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2024 | 12/31/2999 |
| 0813T | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0813T | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0813T | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 6/30/2024 |
| 0816T | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0816T | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0816T | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 6/30/2024 |
| 0818T | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| 0818T | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0818T | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 6/30/2024 |
| 0823T | Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 0824T | Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 0825T | Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 0826T | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| 0858T | Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0858T | Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0858T | Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | 9/30/2024 |
| 0861T | Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0862T | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0863T | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| 0864T | Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| 0864T | Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| 0864T | Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 6/30/2024 |
| 0870T | Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0871T | Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0872T | Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0873T | Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0874T | Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0875T | Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2024 | 12/31/2999 |
| 0889T | Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0890T | Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0891T | Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 0892T | Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| 9701A | NON-PRESCRIPTION DRUGS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A0021 | Ambulance service, outside state per mile, transport (medicaid only) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |

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| A0080 | Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0090 | Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0100 | Non-emergency transportation; taxi | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0110 | Non-emergency transportation and bus, intra or inter state carrier | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0120 | Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0130 | Non-emergency transportation: wheel-chair van | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0140 | Non-emergency transportation and air travel (private or commercial) intra or inter state | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0160 | Non-emergency transportation: per mile - case worker or social worker | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0170 | Transportation ancillary: parking fees, tolls, other | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0180 | Non-emergency transportation: ancillary: lodging-recipient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0190 | Non-emergency transportation: ancillary: meals-recipient | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0200 | Non-emergency transportation: ancillary: lodging escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0210 | Non-emergency transportation: ancillary: meals-escort | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0225 | Ambulance service, neonatal transport, base rate, emergency transport, one way | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0380 | BLS mileage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0382 | Basic Life Support (BLS) routine disposable supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0384 | BLS specialized service disposable supplies; defibrillation (used by ALS (Advanced Life Support) ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0390 | ALS mileage | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0392 | ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0394 | ALS specialized service disposable supplies; IV drug therapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |

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| A0396 | ALS specialized service disposable supplies; esophageal intubation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0398 | ALS routine disposable supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0420 | Ambulance waiting time (ALS or BLS), one half (1/2) hour increments | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0422 | Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0424 | Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0425 | Ground mileage, per statute mile | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0426 | Ambulance service, advanced life support, non-emergency transport, level 1 (als 1) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2014 | 12/31/2999 |
| A0426 | Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0427 | Ambulance service, advanced life support, emergency transport, Level 1 (ALS1-Emergency) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0428 | Ambulance service, basic life support, non-emergency transport (BLS) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0429 | Ambulance service, basic life support, emergency transport (BLS-Emergency) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2007 | 12/31/2999 |
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0432 | Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0433 | Advanced life support, Level 2 (ALS2) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0434 | Specialty care transport (SCT) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0436 | Rotary wing air mileage, per statute mile | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| A0436 | Rotary wing air mileage, per statute mile | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A0888 | Noncovered ambulance mileage, per mile (e. G. , for miles traveled beyond closest appropriate facility) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| A0998 | Ambulance response and treatment, no transport | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| A2001 | Innovamatrix ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2001 | Innovamatrix ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2002 | Mirragen advanced wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2002 | Mirragen advanced wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2004 | Xcellistem, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2004 | Xcellistem, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2005 | Microlyte matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2005 | Microlyte matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2006 | Novosorb synpath dermal matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2006 | Novosorb synpath dermal matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2007 | Restrata, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2007 | Restrata, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2008 | Theragenesis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2008 | Theragenesis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |

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| A2009 | Symphony, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2009 | Symphony, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2010 | Apis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2010 | Apis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| A2011 | Supra sdrm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2011 | Supra sdrm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2012 | Suprathel, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2012 | Suprathel, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2013 | Innovamatrix fs, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2013 | Innovamatrix fs, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| A2014 | Omeza collagen matrix, per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2014 | Omeza collagen matrix, per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2015 | Phoenix wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2015 | Phoenix wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2016 | Permeaderm b, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2016 | Permeaderm b, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |

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| A2017 | Permeaderm glove, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2017 | Permeaderm glove, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2018 | Permeaderm c, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2018 | Permeaderm c, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A2019 | Kerecis omega3 marigen shield, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2019 | Kerecis omega3 marigen shield, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2020 | Ac5 advanced wound system (ac5) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2020 | Ac5 advanced wound system (ac5) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2021 | Neomatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2021 | Neomatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A2022 | Innovaburn or innovamatrix xl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2022 | Innovaburn or innovamatrix xl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2023 | Innovamatrix pd, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2023 | Innovamatrix pd, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2024 | Resolve matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2024 | Resolve matrix or xenopatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |

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| A2025 | Miro3d, per cubic centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2025 | Miro3d, per cubic centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| A2026 | Restrata minimatrix, 5 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| A2026 | Restrata minimatrix, 5 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| A4100 | Skin substitute, fda cleared as a device, not otherwise specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2022 | 12/31/2999 |
| A4244 | Alcohol or peroxide, per pint | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4246 | Betadine or phisohex solution, per pint | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4247 | Betadine or iodine swabs/wipes, per box | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4335 | Incontinence supply; miscellaneous | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4341 | Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |
| A4342 | Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |
| A4450 | Tape, non-waterproof, per 18 square inches | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4452 | Tape, waterproof, per 18 square inches | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4458 | Enema bag with tubing, reusable | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4465 | Non-elastic binder for extremity | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4490 | Surgical stockings above knee length, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4495 | Surgical stockings thigh length, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4500 | Surgical stockings below knee length, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4510 | Surgical stockings full length, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4520 | INCONTINENCE GARMENT, ANY TYPE, (E.G. BRIEF, DIAPER), EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| A4540 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| A4540 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |

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| A4540 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| A4541 | Monthly supplies for use of device coded at e0733 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| A4542 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| A4542 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| A4542 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| A4554 | Disposable underpads, all sizes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4555 | Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2017 | 12/31/2999 |
| A4558 | CONDUCTIVE GEL OR PASTE, FOR USE WITH ELECTRICAL DEVICE (E.G., TENS, NMES), PER OZ | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4560 | Neuromuscular electrical stimulator (nmes), disposable, replacement only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | 12/31/2999 |
| A4560 | Neuromuscular electrical stimulator (nmes), disposable, replacement only | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/15/2024 | 12/31/2999 |
| A4560 | Neuromuscular electrical stimulator (nmes), disposable, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 1/14/2024 |
| A4575 | Topical hyperbaric oxygen chamber, disposable | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| A4575 | Topical hyperbaric oxygen chamber, disposable | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| A4596 | Cranial electrotherapy stimulation (ces) system supplies and accessories, per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A4596 | Cranial electrotherapy stimulation (ces) system supplies and accessories, per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2023 | 12/31/2999 |
| A4600 | SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| A4638 | Replacement battery for patient-owned ear pulse generator, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| A4639 | Replacement pad for infrared heating pad system, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| A4639 | Replacement pad for infrared heating pad system, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| A4890 | Contracts, repair and maintenance, for hemodialysis equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| A4927 | Gloves, non-sterile, per 100 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4931 | Oral thermometer, reusable, any type, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A4932 | Rectal thermometer, reusable, any type, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A6000 | Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| A6000 | Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| A6216 | Gauze, non-impregnated, non-sterile, pad size 16 sq. In. Or less, without adhesive border, each dressing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A6217 | Gauze, non-impregnated, non-sterile, pad size more than 16 sq. In. But less than or equal to 48 sq. In. , without adhesive border, each dressing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A6218 | Gauze, non-impregnated, non-sterile, pad size more than 48 sq. In. , without adhesive border, each dressing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A6530 | Gradient compression stocking, below knee, 18-30 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6531 | Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6533 | Gradient compression stocking, thigh length, 18-30 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6534 | Gradient compression stocking, thigh length, 30-40 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6536 | Gradient compression stocking, full length/chap style, 18-30 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6537 | Gradient compression stocking, full length/chap style, 30-40 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6539 | Gradient compression stocking, waist length, 18-30 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6540 | Gradient compression stocking, waist length, 30-40 mmhg, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6544 | Gradient compression stocking, garter belt | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A6549 | Gradient compression garment, not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A7049 | Expiratory positive airway pressure intranasal resistance valve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A7049 | Expiratory positive airway pressure intranasal resistance valve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| A9150 | Non-prescription drugs | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A9152 | SINGLE VITAMIN/MINERAL/TRACE ELEMENT, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |

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| A9153 | MULTIPLE VITAMINS, WITH OR WITHOUT MINERALS AND TRACE ELEMENTS, ORAL, PER DOSE, NOT OTHERWISE SPECIFIED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| A9270 | Non-covered item or service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| A9273 | Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2011 | 12/31/2999 |
| A9282 | WIG, ANY TYPE, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| A9285 | Inversion/eversion correction device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| A9285 | Inversion/eversion correction device | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| A9291 | Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 1/31/2024 |
| A9291 | Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 1/31/2024 |
| A9291 | Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 12/31/2999 |
| A9300 | Exercise equipment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| B4102 | ENTERAL FORMULA, FOR ADULTS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4103 | ENTERAL FORMULA, FOR PEDIATRICS, USED TO REPLACE FLUIDS AND ELECTROLYTES (E.G. CLEAR LIQUIDS), 500 ML = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4104 | ADDITIVE FOR ENTERAL FORMULA (E.G. FIBER) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4105 | In-line cartridge containing digestive enzyme(s) for enteral feeding, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2019 | 12/31/2999 |
| B4149 | ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4150 | Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1. 5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| B4154 | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2013 | 12/31/2999 |
| B4158 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4159 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE SOY BASED WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER AND/OR IRON, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4160 | ENTERAL FORMULA, FOR PEDIATRICS, NUTRITIONALLY COMPLETE CALORICALLY DENSE (EQUAL TO OR GREATER THAN 0.7 KCAL/ML) WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| B4164 | Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| C1052 | Hemostatic agent, gastrointestinal, topical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| C1052 | Hemostatic agent, gastrointestinal, topical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| C1062 | Intravertebral body fracture augmentation with implant (e.g., metal, polymer) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| C1605 | Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| C1761 | Catheter, transluminal intravascular lithotripsy, coronary | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| C1764 | Event recorder, cardiac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| C1776 | Joint device (implantable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2017 | 12/31/2999 |
| C1778 | Lead, neurostimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| C1783 | Ocular implant, aqueous drainage assist device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2015 | 12/31/2999 |
| C1817 | Septal defect imp sys | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2014 | 12/31/2999 |

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| C1818 | Integrated keratoprosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| C1820 | Generator, neurostimulator (implantable), with rechargeable battery and charging system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 |
| C1822 | Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| C1823 | Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| C1823 | Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| C1824 | Generator, cardiac contractility modulation (implantable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| C1825 | Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2021 | 12/31/2999 |
| C1826 | Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| C1827 | Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| C1827 | Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| C1832 | Autograft suspension, including cell processing and application, and all system components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| C1832 | Autograft suspension, including cell processing and application, and all system components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| C1832 | Autograft suspension, including cell processing and application, and all system components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 5/14/2024 |
| C1833 | Monitor, cardiac, including intracardiac lead and all system components (implantable) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| C2623 | Catheter, transluminal angioplasty, drug-coated, non-laser | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2016 | 12/31/2999 |
| C2624 | Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019 | 12/31/2999 |
| C5271 | Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5272 | Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5273 | Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |

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| C5274 | Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5275 | Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5276 | Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5277 | Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C5278 | Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| C9160 | Injection, daxibotulinumtoxina-lanm, 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 3/31/2024 |
| C9161 | Injection, aflibercept hd, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 3/31/2024 |
| C9168 | Injection, mirikizumab-mrkz, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | 6/30/2024 |
| C9354 | Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9354 | Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9356 | Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9356 | Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9358 | Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| C9358 | Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9360 | Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9360 | Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9363 | Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| C9363 | Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| C9364 | Porcine implant, Permacol, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9364 | Porcine implant, Permacol, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| C9734 | Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2014 | 12/31/2999 |
| C9739 | Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| C9740 | Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2015 | 12/31/2999 |
| C9757 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| C9757 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| C9764 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |
| C9765 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplastyš within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |
| C9766 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |

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| C9767 | Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2021 | 12/31/2999 |
| C9768 | Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| C9768 | Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| C9769 | Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2020 | 12/31/2999 |
| C9772 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9772 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9773 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9773 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9774 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9774 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9775 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9775 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9777 | Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |
| C9777 | Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/15/2021 | 12/31/2999 |

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| C9782 | Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2024 | 12/31/2999 |
| C9784 | Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| C9784 | Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| C9785 | Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| C9785 | Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| C9786 | Echocardiography image post processing for computer aided detection of heart failure with preserved ejection fraction, including interpretation and report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 |
| C9793 | 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | 12/31/2999 |
| C9796 | Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| C9796 | Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis]) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| C9796 | Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis]) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 6/30/2024 |
| D3410 | apicoectomy - anterior | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| D7210 | extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| D7220 | removal of impacted tooth - soft tissue | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| D7230 | removal of impacted tooth - partially bony | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| D8210 | removable appliance therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| D8220 | fixed appliance therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0162 | Sitz bath chair | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0183 | Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| E0187 | Water pressure mattress | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| E0190 | POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 2/1/2010 | 12/31/2999 |
| E0210 | Electric heat pad, standard | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0215 | Electric heat pad, moist | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0217 | Water circulating heat pad with pump | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 6/1/2006 | 12/31/2999 |
| E0218 | Fluid circulating cold pad with pump, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0221 | Infrared heating pad system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0221 | Infrared heating pad system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0231 | Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0231 | Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0232 | Warming card for use with the non contact wound warming device and non contact wound warming wound cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0232 | Warming card for use with the non contact wound warming device and non contact wound warming wound cover | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0236 | Pump for water circulating pad | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0240 | Bath/shower chair, with or without wheels, any size | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0241 | Bath tub wall rail, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0242 | Bath tub rail, floor base | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0243 | Toilet rail, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0244 | Raised toilet seat | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| E0245 | Tub stool or bench | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0246 | Transfer tub rail attachment | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0247 | Transfer bench for tub or toilet with or without commode opening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0248 | Transfer bench, heavy duty, for tub or toilet with or without commode opening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0249 | PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2006 | 12/31/2999 |
| E0273 | Bed board | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0274 | Over-bed table | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0280 | Bed cradle, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| E0291 | Hospital bed, fixed height, without side rails, without mattress | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2014 | 12/31/2999 |
| E0293 | Hospital bed, variable height, hi-lo, without side rails, without mattress | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2014 | 12/31/2999 |
| E0315 | Bed accessory: board, table, or support device, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0316 | Safety enclosure frame/canopy for use with hospital bed, any type | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| E0462 | Rocking bed with or without side rails | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0485 | ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 7/31/2024 |
| E0487 | SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0487 | SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0490 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| E0490 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| E0491 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| E0491 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |

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| E0492 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| E0493 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| E0530 | Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| E0616 | Implantable cardiac event recorder with memory, activator and programmer | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0617 | External defibrillator with integrated electrocardiogram analysis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/16/2019 | 12/31/2999 |
| E0620 | Skin piercing device for collection of capillary blood, laser, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0650 | Pneumatic compressor, non-segmental home model | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0651 | Pneumatic compressor, segmental home model without calibrated gradient pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0652 | Pneumatic compressor, segmental home model with calibrated gradient pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0655 | Non-segmental pneumatic appliance for use with pneumatic compressor, half arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0656 | SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| E0657 | SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| E0660 | Non-segmental pneumatic appliance for use with pneumatic compressor, full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0665 | Non-segmental pneumatic appliance for use with pneumatic compressor, full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0666 | Non-segmental pneumatic appliance for use with pneumatic compressor, half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0667 | Segmental pneumatic appliance for use with pneumatic compressor, full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0668 | Segmental pneumatic appliance for use with pneumatic compressor, full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0669 | Segmental pneumatic appliance for use with pneumatic compressor, half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0670 | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| E0671 | Segmental gradient pressure pneumatic appliance, full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0672 | Segmental gradient pressure pneumatic appliance, full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0673 | Segmental gradient pressure pneumatic appliance, half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| E0675 | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| E0675 | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| E0676 | INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2007 | 12/31/2999 |
| E0677 | Non-pneumatic sequential compression garment, trunk | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| E0678 | Non-pneumatic sequential compression garment, full leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0679 | Non-pneumatic sequential compression garment, half leg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0680 | Non-pneumatic compression controller with sequential calibrated gradient pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0681 | Non-pneumatic compression controller without calibrated gradient pressure | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0682 | Non-pneumatic sequential compression garment, full arm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0691 | ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2006 | 12/31/2999 |
| E0692 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2006 | 12/31/2999 |
| E0693 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2006 | 12/31/2999 |
| E0694 | Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2006 | 12/31/2999 |
| E0700 | SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0732 | Cranial electrotherapy stimulation (ces) system, any type | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0732 | Cranial electrotherapy stimulation (ces) system, any type | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0732 | Cranial electrotherapy stimulation (ces) system, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| E0733 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| E0735 | Non-invasive vagus nerve stimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| E0736 | Transcutaneous tibial nerve stimulator | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |

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| E0740 | Non-implanted pelvic floor electrical stimulator, complete system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0740 | Non-implanted pelvic floor electrical stimulator, complete system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0744 | Neuromuscular stimulator for scoliosis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| E0746 | Electromyography (emg), biofeedback device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 12/31/2999 |
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0755 | Electronic salivary reflex stimulator (intra-oral/non-invasive) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E0760 | Osteogenesis stimulator, low intensity ultrasound, non-invasive | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0761 | Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| E0762 | TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0762 | TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0764 | FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| E0764 | FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| E0766 | Electrical stimulation device used for cancer treatment, includes all accessories, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2017 | 12/31/2999 |
| E0769 | ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0769 | ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0781 | Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2005 | 12/31/2999 |
| E0830 | Ambulatory traction device, all types, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |

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| E0830 | Ambulatory traction device, all types, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0840 | Traction frame, attached to headboard, cervical traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0840 | Traction frame, attached to headboard, cervical traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0849 | TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0849 | TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THAN MANDIBLE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0850 | Traction stand, free standing, cervical traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0850 | Traction stand, free standing, cervical traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0855 | Cervical traction equipment not requiring additional stand or frame | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0855 | Cervical traction equipment not requiring additional stand or frame | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| E0856 | Cervical traction device, with inflatable air bladder(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0856 | Cervical traction device, with inflatable air bladder(s) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0860 | Traction equipment, overdoor, cervical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0860 | Traction equipment, overdoor, cervical | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0890 | Traction frame, attached to footboard, pelvic traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0890 | Traction frame, attached to footboard, pelvic traction | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0920 | Fracture frame, attached to bed, includes weights | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2005 | 12/31/2999 |
| E0930 | Fracture frame, free standing, includes weights | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2005 | 12/31/2999 |

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| E0936 | CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| E0936 | CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| E0941 | Gravity assisted traction device, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2005 | 12/31/2999 |
| E0942 | Cervical head harness/halter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0942 | Cervical head harness/halter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0944 | Pelvic belt/harness/boot | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0944 | Pelvic belt/harness/boot | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| E0946 | Fracture, frame, dual with cross bars, attached to bed, (e. G. Balken, 4 poster) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2005 | 12/31/2999 |
| E0948 | Fracture frame, attachments for complex cervical traction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| E0950 | Wheelchair accessory, tray, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0953 | Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| E0954 | Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| E0955 | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E0969 | Narrowing device, wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E0981 | Wheelchair accessory, seat upholstery, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0982 | Wheelchair accessory, back upholstery, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0983 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E0984 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E0985 | Wheelchair accessory, seat lift mechanism | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E0986 | Manual wheelchair accessory, push-rim activated power assist system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E0988 | MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E0990 | Wheelchair accessory, elevating leg rest, complete assembly, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |

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| E0992 | Manual wheelchair accessory, solid seat insert | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1002 | Wheelchair accessory, power seating system, tilt only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1005 | Wheelchair accessory, power seatng system, recline only, with power shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1007 | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1008 | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1009 | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1010 | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E1012 | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| E1028 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1083 | Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1085 | Hemi-wheelchair, fixed full length arms, swing away detachable foot rests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1087 | High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1170 | Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1171 | Amputee wheelchair, fixed full length arms, without footrests or legrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1172 | Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1180 | Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1195 | Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1200 | Amputee wheelchair, fixed full length arms, swing away detachable footrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1220 | Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1221 | Wheelchair with fixed arm, footrests | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |

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| E1225 | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1226 | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1227 | Special height arms for wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1228 | Special back height for wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1229 | WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1230 | Power operated vehicle (three or four wheel nonhighway) specify brand name and model number | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1231 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1239 | POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E1285 | Heavy duty wheelchair, fixed full length arms, swing away detachable footrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1295 | Heavy duty wheelchair, fixed full length arms, elevating legrest | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E1300 | Whirlpool, portable (overtub type) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E1301 | Whirlpool tub, walk-in, portable | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| E1310 | Whirlpool, non-portable (built-in type) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E1355 | Stand/rack | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E1629 | Tablo hemodialysis system for the billable dialysis service | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| E1632 | Wearable artificial kidney, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| E1632 | Wearable artificial kidney, each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| E1700 | Jaw motion rehabilitation system | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E1701 | Replacement cushions for jaw motion rehabilitation system, pkg. Of 6 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E1702 | Replacement measuring scales for jaw motion rehabilitation system, pkg. Of 200 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| E2120 | Pulse generator system for tympanic treatment of inner ear endolymphatic fluid | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| E2201 | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2202 | Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2203 | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |

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| E2204 | Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2206 | Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2207 | WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 6/1/2006 | 12/31/2999 |
| E2209 | ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2211 | MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2212 | MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2213 | MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE), ANY TYPE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2214 | MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2215 | MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2216 | MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2217 | MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2218 | MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2219 | MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2220 | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2221 | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2222 | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2228 | MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| E2230 | MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| E2231 | MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| E2291 | Back, planar, for pediatric size wheelchair including fixed attaching hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2292 | Seat, planar, for pediatric size wheelchair including fixed attaching hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2293 | Back, contoured, for pediatric size wheelchair including fixed attaching hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2294 | Seat, contoured, for pediatric size wheelchair including fixed attaching hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |

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| E2295 | MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| E2298 | Complex rehabilitative power wheelchair accessory, power seat elevation system, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| E2300 | Wheelchair accessory, power seat elevation system, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 3/31/2024 |
| E2301 | Wheelchair accessory, power standing system, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2007 | 12/31/2999 |
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2007 | 12/31/2999 |
| E2312 | POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| E2313 | POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| E2321 | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2323 | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2324 | Power wheelchair accessory, chin cup for chin control interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2325 | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2329 | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |

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| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2331 | Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| E2340 | Power wheelchair accessory, nonstandard seat frame width, 20-23 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2341 | Power wheelchair accessory, nonstandard seat frame width, 24-27 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2342 | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2343 | Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2351 | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2358 | POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| E2359 | POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| E2360 | Power wheelchair accessory, 22 nf non-sealed lead acid battery, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2361 | Power wheelchair accessory, 22nf sealed lead acid battery, each, (e. G. Gel cell, absorbed glassmat) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2362 | Power wheelchair accessory, group 24 non-sealed lead acid battery, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2363 | Power wheelchair accessory, group 24 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2364 | Power wheelchair accessory, u-1 non-sealed lead acid battery, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2365 | Power wheelchair accessory, u-1 sealed lead acid battery, each (e. G. Gel cell, absorbed glassmat) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2366 | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2367 | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2371 | POWER WHEELCHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL CELL, ABSORBED GLASSMAT), EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2372 | POWER WHEELCHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |

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| E2374 | POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2375 | POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2376 | POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2377 | POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2397 | POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| E2500 | Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2502 | Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2504 | Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2506 | Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2508 | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2510 | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2511 | Speech generating software program, for personal computer or personal digital assistant | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2512 | Accessory for speech generating device, mounting system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2599 | Accessory for speech generating device, not otherwise classified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| E2601 | GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2602 | GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2603 | SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2604 | SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2605 | POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |

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| E2606 | POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2607 | SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2608 | SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2609 | CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2611 | GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2612 | GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2613 | POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2614 | POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2615 | POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2616 | POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2617 | CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2620 | POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2621 | POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2005 | 12/31/2999 |
| E2622 | SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| E2623 | SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| E2624 | SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| E2625 | SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| E2626 | WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |

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| E2627 | WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2628 | WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2629 | WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2630 | WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2631 | WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2632 | WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E2633 | WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2014 | 12/31/2999 |
| E3000 | Speech volume modulation system, any type, including all components and accessories | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E3000 | Speech volume modulation system, any type, including all components and accessories | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| E3000 | Speech volume modulation system, any type, including all components and accessories | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 5/14/2024 |
| G0176 | 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) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2006 | 12/31/2999 |
| G0255 | Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0255 | Current perception threshold/sensory nerve conduction test, (snct) per limb, any nerve | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0276 | Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (pild) or placebo-control, performed in an approved coverage with evidence development (ced) clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2015 | 12/31/2999 |
| G0281 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |

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| G0281 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0282 | Electrical stimulation, (unattended), to one or more areas, for wound care other than described in 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). | 12/15/2014 | 12/31/2999 |
| G0282 | Electrical stimulation, (unattended), to one or more areas, for wound care other than described in 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). | 12/15/2014 | 12/31/2999 |
| G0293 | Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a medicare qualifying clinical trial, per day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| G0294 | Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a medicare qualifying clinical trial, per day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| G0295 | Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0295 | Electromagnetic therapy, to one or more areas, for wound care other than described in g0329 or for other uses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0329 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0329 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| G0341 | Percutaneous islet cell transplant, includes portal vein catheterization and infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| G0342 | Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| G0343 | Laparotomy for islet cell transplant, includes portal vein catheterization and infusion | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| G0416 | Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2013 | 12/31/2999 |
| G0428 | Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| G0428 | Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| G0429 | Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy.) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |

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| G0455 | Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| G0460 | Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| G0460 | Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| G0465 | Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| G0465 | Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2022 | 12/31/2999 |
| G0516 | Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 9/14/2024 |
| G0518 | Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 9/14/2024 |
| G2082 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2021 | 12/31/2999 |
| G2083 | Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2021 | 12/31/2999 |
| G8395 | LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8396 | LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8397 | DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8399 | Patient with documented results of a central dual-energy x-ray absorptiometry (dxa) ever being performed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8400 | Patient with central dual-energy x-ray absorptiometry (dxa) results not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8404 | LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8405 | LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |

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| G8410 | FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8415 | FOOTWEAR EVALUATION WAS NOT PERFORMED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8416 | CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8417 | Bmi is documented above normal parameters and a follow-up plan is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8418 | Bmi is documented below normal parameters and a follow-up plan is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8419 | Bmi documented outside normal parameters, no follow-up plan documented, no reason given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8420 | Bmi is documented within normal parameters and no follow-up plan is required | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8421 | Bmi not documented and no reason is given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8427 | Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8428 | Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8430 | Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8431 | Screening for depression is documented as being positive and a follow-up plan is documented | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8432 | Depression screening not documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8433 | Screening for depression not completed, documented patient or medical reason | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8450 | Beta-blocker therapy prescribed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8451 | Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8452 | Beta-blocker therapy not prescribed | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8465 | High or very high risk of recurrence of prostate cancer | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8473 | ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8474 | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |

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| G8475 | Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8476 | Most recent blood pressure has a systolic measurement of < 140 mmhg and a diastolic measurement of < 90 mmhg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8477 | Most recent blood pressure has a systolic measurement of >=140 mmhg and/or a diastolic measurement of >=90 mmhg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8478 | Blood pressure measurement not performed or documented, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8482 | INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY RECEIVED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8483 | 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) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8484 | Influenza immunization was not administered, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G8559 | PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8560 | PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8561 | PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8562 | PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8563 | Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8564 | PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8565 | VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8566 | PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS MEASURE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8567 | PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8568 | Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8569 | Prolonged postoperative intubation (> 24 hrs) required | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8570 | Prolonged postoperative intubation (> 24 hrs) not required | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |

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| G8575 | DEVELOPED POSTOPERATIVE RENAL FAILURE OR REQUIRED DIALYSIS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8576 | NO POSTOPERATIVE RENAL FAILURE/DIALYSIS NOT REQUIRED | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8577 | Re-exploration required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction or other cardiac reason | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8578 | Re-exploration not required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction or other cardiac reason | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8598 | Aspirin or another antiplatelet therapy used | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8599 | Aspirin or another antiplatelet therapy not used, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8600 | Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8601 | Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G8602 | Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2010 | 12/31/2999 |
| G9050 | Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9051 | Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9052 | Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9053 | Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9054 | Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9055 | Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9056 | Oncology; practice guidelines; management adheres to guidelines (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9057 | Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9058 | Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9059 | Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9060 | Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9061 | Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9062 | Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9063 | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage i (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9064 | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage ii (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9065 | Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as stage iii a (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9066 | Oncology; disease status; limited to non-small cell lung cancer; stage iii b- iv at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9067 | Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9068 | Oncology; disease status; limited to small cell and combined small cell/non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9069 | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9070 | Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9071 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i or stage iia-iib; or t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9072 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage i, or stage iia-iib; or t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9073 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9074 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; stage iiia-iiib; and not t3, n1, m0; and er and pr negative; with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9075 | Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9077 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t1-t2c and gleason 2-7 and psa < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9078 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9079 | Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t3b-t4, any n; any t, n1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9080 | Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising psa or failure of psa decline (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9083 | Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9084 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9085 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, n0, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9086 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-4, n1-2, m0 with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9087 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9088 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9089 | Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9090 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-2, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9091 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t3, n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9092 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t1-3, n1-2, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9093 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9094 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9095 | Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9096 | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t1-t3, n0-n1 or nx (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9097 | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as t4, any n, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9098 | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9099 | Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9100 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9101 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post r1 or r2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9102 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m0, unresectable with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9103 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9104 | Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9105 | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post r0 resection without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9106 | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post r1 or r2 resection with no evidence of disease progression, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9107 | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9108 | Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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| G9109 | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t1-t2 and n0, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9110 | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as t3-4 and/or n1-3, m0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9111 | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; m1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9112 | Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9113 | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 1) without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9114 | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage ia-b (grade 2-3); or stage ic (all grades); or stage ii; without evidence of disease progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9115 | Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic stage iii-iv; without evidence of progression, recurrence, or metastases (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9116 | Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9117 | Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| G9123 | Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and/or bcr-abl positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a medicare-approved demonstration project) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |

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

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| G9136 | ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| G9137 | ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| G9138 | ONCOLOGY; DISEASE STATUS; NON-HODGKIN?S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| G9139 | ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| G9140 | FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREVENT TRANSFER OR THE CASE FALLS INTO A CATEGORY OF MONITORING AND OBSERVATION CASES THAT ARE PERMITTED BY THE RULES OF THE DEMONSTRATION; THERE IS A MAXIMUM FRONTIER EXTENDED STAY CLINIC (FESC) VISIT OF 48 HOURS, EXCEPT IN THE CASE WHEN WEATHER OR OTHER CONDITIONS PREVENT TRANSFER; PAYMENT IS MADE ON EACH PERIOD UP TO 4 HOURS, AFTER THE FIRST 4 HOURS | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2008 | 12/31/2999 |
| G9147 | Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| G9147 | Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for:respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J0172 | Injection, aducanumab-avwa, 2 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| J0174 | Injection, lecanemab-irmb, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2023 | 12/31/2999 |

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| J0177 | Injection, aflibercept hd, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| J0178 | Injection, aflibercept, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 |
| J0179 | Injection, brolucizumab-dbll, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 |
| J0202 | Injection, alemtuzumab, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 5/31/2024 |
| J0218 | Injection, olipudase alfa-rpcp, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2023 | 12/31/2999 |
| J0219 | Injection, avalglucosidase alfa-ngpt, 4 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2022 | 12/31/2999 |
| J0220 | INJECTION, ALGLUCOSIDASE ALFA, 10 MG, NOT OTHERWISE SPECIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2008 | 12/31/2999 |
| J0222 | Injection, Patisiran, 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| J0223 | Injection, givosiran, 0.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2024 |
| J0224 | Injection, lumasiran, 0.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2024 |
| J0225 | Injection, vutrisiran, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2024 |
| J0248 | Injection, remdesivir, 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2024 | 12/31/2999 |
| J0485 | Injection, belatacept, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J0491 | Injection, anifrolumab-fnia, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2022 | 12/31/2999 |
| J0517 | Injection, benralizumab, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| J0565 | Injection, bezlotoxumab, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 3/14/2024 |
| J0567 | Injection, cerliponase alfa, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 3/31/2024 |
| J0584 | Injection, burosumab-twza 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 4/30/2024 |
| J0585 | INJECTION, ONABOTULINUMTOXINA, 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| J0587 | INJECTION, RIMABOTULINUMTOXINB, 100 UNITS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 1/31/2024 |
| J0588 | INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 1/31/2024 |
| J0589 | Injection, daxibotulinumtoxina-lanm, 1 unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2024 | 12/31/2999 |
| J0600 | Injection, edetate calcium disodium, up to 1000 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| J0717 | Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 6/14/2024 |

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| J0739 | Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 3/14/2024 |
| J0741 | Injection, cabotegravir and rilpivirine, 2mg/3mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2023 | 12/31/2999 |
| J0775 | INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2011 | 12/31/2999 |
| J0791 | Injection, crizanlizumab-tmca, 5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| J0888 | Injectin, epoetin beta, 1 microgram, (for non esrd use) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| J1203 | Injection, cipaglucosidase alfa-atga, 5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024 | 12/31/2999 |
| J1301 | Injection, edaravone, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| J1302 | Injection, sutimlimab-jome, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| J1303 | Injection, ravulizumab-cwvz, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2020 | 12/31/2999 |
| J1304 | Injection, tofersen, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J1305 | Injection, evinacumab-dgnb, 5mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021 | 12/31/2999 |
| J1306 | Injection, inclisiran, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022 | 12/31/2999 |
| J1325 | Injection, epoprostenol, 0. 5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| J1411 | Injection, etranacogene dezaparvovec-drlb, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023 | 12/31/2999 |
| J1412 | Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J1413 | Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J1426 | Injection, casimersen, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021 | 12/31/2999 |
| J1427 | Injection, viltolarsen, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2021 | 12/31/2999 |
| J1428 | Injection, eteplirsen, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| J1429 | Injection, golodirsen, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020 | 12/31/2999 |
| J1440 | Fecal microbiota, live - jslm, 1 ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2024 | 12/31/2999 |
| J1551 | Injection, immune globulin (cutaquig), 100 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022 | 12/31/2999 |
| J1554 | Injection, immune globulin (asceniv), 500 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021 | 12/31/2999 |
| J1576 | Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 |

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| J1632 | Injection, brexanolone, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2020 | 12/31/2999 |
| J1675 | INJECTION, HISTRELIN ACETATE, 10 MICROGRAMS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2006 | 3/14/2024 |
| J1726 | Injection, hydroxyprogesterone caproate, (makena), 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/15/2023 | 12/31/2999 |
| J1729 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/15/2023 | 12/31/2999 |
| J1746 | Injection, ibalizumab-uiyk, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 3/31/2024 |
| J1747 | Injection, spesolimab-sbzo, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2023 | 12/31/2999 |
| J1823 | Injection, inebilizumab-cdon, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2021 | 12/31/2999 |
| J1930 | INJECTION, LANREOTIDE, 1 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J1951 | Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2021 | 12/31/2999 |
| J1954 | Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2023 | 12/31/2999 |
| J2267 | Injection, mirikizumab-mrkz, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | 12/31/2999 |
| J2278 | INJECTION, ZICONOTIDE, 1 MICROGRAM | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2006 | 5/31/2024 |
| J2327 | Injection, risankizumab-rzaa, intravenous, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2023 | 12/31/2999 |
| J2329 | Injection, ublituximab-xiiy, 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 |
| J2353 | Injection, octreotide, depot form for intramuscular injection, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J2354 | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J2356 | Injection, tezepelumab-ekko, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022 | 12/31/2999 |
| J2502 | Injection, pasireotide long acting, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 4/30/2024 |
| J2508 | Injection, pegunigalsidase alfa-iwxj, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J2777 | Injection, faricimab-svoa, 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| J2778 | INJECTION, RANIBIZUMAB, 0.1 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 |
| J2779 | Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022 | 12/31/2999 |
| J2782 | Injection, avacincaptad pegol, 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024 | 12/31/2999 |
| J2787 | Riboflavin 5'-phosphate, ophthalmic solution, up to 3 mL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| J2796 | INJECTION, ROMIPLOSTIM, 10 MICROGRAMS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |

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| J3032 | Injection, eptinezumab-jjmr, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| J3111 | Injection, romosozumab-aqqg, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J3121 | Injection, testosterone enanthate, 1mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 3/14/2024 |
| J3145 | Injection, testosterone undecanoate, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 3/14/2024 |
| J3241 | Injection, teprotumumab-trbw, 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2020 | 12/31/2999 |
| J3245 | Injection, tildrakizumab, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 5/31/2024 |
| J3247 | Injection, secukinumab, intravenous, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2024 | 12/31/2999 |
| J3299 | Injection, triamcinolone acetonide (xipere), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2022 | 12/31/2999 |
| J3393 | Injection, betibeglogene autotemcel, per treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| J3394 | Injection, lovotibeglogene autotemcel, per treatment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| J3396 | INJECTION, VERTEPORFIN, 0.1 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007 | 12/31/2999 |
| J3398 | Injection, voretigene neparvovec-rzyl, 1 billion vector genomes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| J3399 | Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2020 | 12/31/2999 |
| J3401 | Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J3520 | Edetate disodium, per 150 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| J3570 | Laetrile, amygdalin, vitamin b17 | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 6/1/2015 | 12/31/2999 |
| J7177 | Injection, human fibrinogen concentrate (fibryga), 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| J7178 | Injection, human fibrinogen concentrate, not otherwise specified, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 6/30/2024 |
| J7183 | INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| J7311 | Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/15/2011 | 12/31/2999 |
| J7313 | Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| J7351 | Injection, bimatoprost, intracameral implant, 1 microgram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2020 | 12/31/2999 |
| J7355 | Injection, travoprost, intracameral implant, 1 microgram | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| J7604 | ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| J7604 | ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7607 | LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7607 | LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7609 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7609 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7610 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7610 | ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7615 | LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7615 | LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7622 | BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7622 | BECLOMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7624 | BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7624 | BETAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7627 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7627 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7628 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| J7628 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7629 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7629 | BITOLTEROL MESYLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7632 | CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7632 | CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7634 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7634 | BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7635 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7635 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7636 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7636 | ATROPINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7637 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7637 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7638 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7638 | DEXAMETHASONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7640 | FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| J7640 | FORMOTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 12 MICROGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7641 | FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7641 | FLUNISOLIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7642 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7642 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7643 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7643 | GLYCOPYRROLATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7645 | IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7645 | IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7647 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7647 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7650 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7650 | ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7657 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7657 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7660 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| J7660 | ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7667 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7667 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7670 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7670 | METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7676 | PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7676 | PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7680 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7680 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7681 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7681 | TERBUTALINE SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7683 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7683 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7684 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7684 | TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J7685 | TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| J7685 | TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| J9029 | Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 |
| J9037 | Injection, belantamab mafodontin-blmf, 0.5 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| J9057 | Injection, copanlisib, 1 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| J9285 | Injection, olaratumab, 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 9/1/2019 | 12/31/2999 |
| J9313 | Injection, moxetumomab pasudotox-tdfk, 0.01 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| J9332 | Injection, efgartigimod alfa-fcab, 2mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2022 | 12/31/2999 |
| J9333 | Injection, rozanolixizumab-noli, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J9334 | Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/15/2024 | 12/31/2999 |
| J9376 | Injection, pozelimab-bbfg, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2024 | 12/31/2999 |
| J9381 | Injection, teplizumab-mzwv, 5 mcg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2023 | 12/31/2999 |
| J9600 | INJECTION, PORFIMER SODIUM, 75 MG | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2006 | 12/31/2999 |
| K0010 | Standard - weight frame motorized/power wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0011 | Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0012 | Lightweight portable motorized/power wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0013 | Custom Motorized/Power Wheelchair Base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2013 | 12/31/2999 |
| K0014 | Other motorized/power wheelchair base | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0053 | Elevating footrests, articulating (telescoping), each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0056 | Seat height less than 17 or equal to or greater than 21 for a high strength, lightweight, or ultralightweight wheelchair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2006 | 12/31/2999 |
| K0108 | Wheelchair component or accessory, not otherwise specified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0455 | Infusion pump used for uninterrupted parenteral administration of medication, (e. G. , epoprostenol or treprostinol) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0669 | Seat/back custom; no dme pdac ver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| K0743 | SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2011 | 12/31/2999 |

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| K0744 | ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2011 | 12/31/2999 |
| K0746 | ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2011 | 12/31/2999 |
| K0800 | POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0801 | POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0802 | POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0806 | POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0807 | POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0808 | POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0812 | POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0813 | POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0814 | POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0815 | POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0816 | POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0820 | POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0821 | POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0822 | POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0823 | POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0824 | POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |

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| K0825 | POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0826 | POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0827 | POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0828 | POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0829 | POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0830 | POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0831 | POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0835 | POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0836 | POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0837 | POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0838 | POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0839 | POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0840 | POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0841 | POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0842 | POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0843 | POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0848 | POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |

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| K0849 | POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0850 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0851 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0852 | POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0853 | POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0854 | POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0855 | POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0856 | POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0857 | POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0858 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0859 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0860 | POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0861 | POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0862 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0863 | POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0864 | POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0868 | POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |

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| K0869 | POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0870 | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0871 | POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0877 | POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0878 | POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0879 | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0880 | POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0884 | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0885 | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0886 | POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0890 | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0891 | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K0899 | Power mobile device; no dme pdac | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2006 | 12/31/2999 |
| K1004 | Low frequency ultrasonic diathermy treatment device for home use | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| K1004 | Low frequency ultrasonic diathermy treatment device for home use | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| K1007 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |

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| K1007 | 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 | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| K1027 | Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021 | 7/31/2024 |
| K1030 | External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2022 | 12/31/2999 |
| K1036 | Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| K1036 | Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/15/2024 | 9/30/2024 |
| L1320 | Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| L1834 | Knee orthosis, without knee joint, rigid, custom-fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| L1840 | Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| L1844 | KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| L1846 | KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| L3040 | Foot, arch support, removable, premolded, longitudinal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| L3050 | Foot, arch support, removable, premolded, metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| L3060 | Foot, arch support, removable, premolded, longitudinal/ metatarsal, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| L5610 | Addition to lower extremity, endoskeletal system, above knee, hydracadence system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |

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| L5611 | Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5613 | Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5614 | Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5615 | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| L5616 | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5620 | Addition to lower extremity, test socket, below knee | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5624 | Addition to lower extremity, test socket, above knee | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5629 | Addition to lower extremity, below knee, acrylic socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5631 | Addition to lower extremity, above knee or knee disarticulation, acrylic socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5638 | Addition to lower extremity, below knee, leather socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5639 | Addition to lower extremity, below knee, wood socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5640 | Addition to lower extremity, knee disarticulation, leather socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5642 | Addition to lower extremity, above knee, leather socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5644 | Addition to lower extremity, above knee, wood socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5645 | Addition to lower extremity, below knee, flexible inner socket, external frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5646 | Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5647 | Addition to lower extremity, below knee suction socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5648 | Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5651 | Addition to lower extremity, above knee, flexible inner socket, external frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5652 | Addition to lower extremity, suction suspension, above knee or knee disarticulation socket | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5670 | Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5676 | Additions to lower extremity, below knee, knee joints, single axis, pair | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5704 | Custom shaped protective cover, below knee | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |

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| L5705 | Custom shaped protective cover, above knee | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5706 | Custom shaped protective cover, knee disarticulation | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5710 | Addition, exoskeletal knee-shin system, single axis, manual lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5711 | Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5712 | Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5714 | Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5716 | Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5718 | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5722 | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5724 | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5726 | Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5728 | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5780 | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5785 | Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5790 | Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5795 | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5810 | Addition, endoskeletal knee-shin system, single axis, manual lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5811 | Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5812 | Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5814 | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5816 | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5818 | Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5822 | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5824 | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5826 | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |

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| L5828 | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5830 | Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5840 | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5841 | Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| L5848 | ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5856 | ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2007 | 12/31/2999 |
| L5858 | ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2007 | 12/31/2999 |
| L5859 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2013 | 12/31/2999 |
| L5926 | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| L5961 | ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| L5962 | Addition, endoskeletal system, below knee, flexible protective outer surface covering system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5964 | Addition, endoskeletal system, above knee, flexible protective outer surface covering system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5966 | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5968 | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2015 | 12/31/2999 |
| L5969 | Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| L5970 | All lower extremity prostheses, foot, external keel, sach foot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5972 | All lower extremity prostheses, foot, flexible keel | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5973 | ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |

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| L5974 | All lower extremity prostheses, foot, single axis ankle/foot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5976 | All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5978 | All lower extremity prostheses, foot, multiaxial ankle/foot | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5979 | All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5980 | All lower extremity prostheses, flex foot system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5981 | All lower extremity prostheses, flex-walk system or equal | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5982 | All exoskeletal lower extremity prostheses, axial rotation unit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5984 | All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5985 | All endoskeletal lower extremity prostheses, dynamic prosthetic pylon | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5986 | All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5987 | All lower extremity prosthesis, shank foot system with vertical loading pylon | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2006 | 12/31/2999 |
| L5991 | Addition to lower extremity prostheses, osseointegrated external prosthetic connector | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| L5991 | Addition to lower extremity prostheses, osseointegrated external prosthetic connector | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| L6026 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| L6611 | ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6621 | UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6880 | ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2012 | 12/31/2999 |
| L6882 | Microprocessor control feature, addition to upper limb prosthetic terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6920 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |

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| L6925 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6930 | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6935 | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6940 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6945 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6950 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6955 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6960 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6965 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6970 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L6975 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7007 | ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7008 | ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |

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| L7009 | ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7040 | PREHENSILE ACTUATOR, SWITCH CONTROLLED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7045 | ELECTRIC HOOK, SWITCH OR MYOELECTRIC ONTROLLED, PEDIATRIC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7170 | Electronic elbow, hosmer or equal, switch controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7180 | Electronic elbow, microprocessor sequential control of elbow and terminal device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7181 | ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7185 | Electronic elbow, adolescent, variety village or equal, switch controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7186 | Electronic elbow, child, variety village or equal, switch controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7190 | Electronic elbow, adolescent, variety village or equal, myoelectronically controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7191 | Electronic elbow, child, variety village or equal, myoelectronically controlled | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7259 | Electronic wrist rotator, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| L7360 | Six volt battery, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7362 | Battery charger, six volt, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7364 | Twelve volt battery, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7366 | Battery charger, twelve volt, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7367 | Lithium ion battery, rechargeable, replacement | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| L7368 | LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2007 | 12/31/2999 |
| L8603 | Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| L8603 | Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2024 | 12/31/2999 |
| L8603 | Injectable bulking agent, collagen implant, urinary tract, 2. 5 ml syringe, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 5/14/2024 |
| L8604 | INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, URINARY TRACT, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2009 | 12/31/2999 |
| L8605 | Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| L8605 | Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| L8606 | Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2007 | 12/31/2999 |
| L8607 | Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2016 | 12/31/2999 |
| L8608 | Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| L8608 | Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 9/14/2024 |
| L8609 | ARTIFICIAL CORNEA | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2015 | 12/31/2999 |
| L8612 | Aqueous shunt | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2014 | 12/31/2999 |
| L8678 | Electrical stimulator supplies (external) for use with implantable neurostimulator, per month | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 |
| L8679 | Implantable neurostimulator, pulse generator, any type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8680 | Implantable neurostimulator electrode, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8681 | PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 |
| L8682 | Implantable neurostimulator radiofrequency receiver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/19/2022 | 12/31/2999 |
| L8683 | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 |
| L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8686 | Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8688 | Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| L8689 | EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2023 | 12/31/2999 |
| L8694 | Auditory osseointegrated device, transducer/actuator, replacement only, each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2018 | 12/31/2999 |
| L8695 | EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/19/2022 | 12/31/2999 |
| L8698 | Miscellaneous component, supply or accessory for use with total artificial heart system | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |

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| L8701 | Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| L8702 | Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2019 | 12/31/2999 |
| M0075 | Cellular therapy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| M0100 | Intragastric hypothermia using gastric freezing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| M0240 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0240 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0241 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0241 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0243 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0243 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0244 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |

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| M0244 | Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0245 | Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0245 | Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0246 | Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0246 | Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| M0300 | Iv chelation therapy (chemical endarterectomy) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| M0301 | Fabric wrapping of abdominal aneurysm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| P2029 | Congo red, blood | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| P2031 | Hair analysis (excluding arsenic) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| P9020 | Platelet rich plasma, each unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| P9020 | Platelet rich plasma, each unit | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| P9603 | Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| P9604 | Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge. | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| Q0035 | Cardiokymography | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| Q0240 | Injection, casirivimab and imdevimab, 600 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |

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| Q0240 | Injection, casirivimab and imdevimab, 600 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0243 | Injection, casirivimab and imdevimab, 2400 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0243 | Injection, casirivimab and imdevimab, 2400 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0244 | Injection, casirivimab and imdevimab, 1200 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0244 | Injection, casirivimab and imdevimab, 1200 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0245 | Injection, bamlanivimab and etesevimab, 2100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0245 | Injection, bamlanivimab and etesevimab, 2100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 6/1/2023 | 12/31/2999 |
| Q0482 | Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0485 | Monitor control cable for use with electric ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0487 | Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0490 | Emergency power source for use with electric ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0492 | Emergency power supply cable for use with electric ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0494 | Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0502 | Mobility cart for pneumatic ventricular assist device, replacement only | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0504 | Power adapter for pneumatic ventricular assist device, replacement only, vehicle type | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2005 | 12/31/2999 |
| Q0510 | PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S), FIRST MONTH FOLLOWING transPLANT | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| Q0511 | PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNOSUPPRESSIVE DRUG(S); FOR THE FIRST PRESCRIPTION IN A 30-DAY PERIOD | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| Q0512 | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2006 | 12/31/2999 |
| Q0516 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/2/2024 | 12/31/2999 |
| Q0517 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/2/2024 | 12/31/2999 |

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| Q0518 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/2/2024 | 12/31/2999 |
| Q2026 | INJECTION, RADIESSE, 0.1 ML | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2013 | 12/31/2999 |
| Q2028 | Injection, sculptra, 0.5 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| Q2041 | Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2018 | 12/31/2999 |
| Q2042 | Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2011 | 12/31/2999 |
| Q2049 | Injection, Doxorubicin Hydrochloride, Liposomal, Imported Lipodox, 10 mg | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2024 | 12/31/2999 |
| Q2052 | Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2014 | 12/31/2999 |
| Q2053 | Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2021 | 12/31/2999 |
| Q2054 | Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2021 | 12/31/2999 |
| Q2055 | Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2022 | 12/31/2999 |
| Q2056 | Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2022 | 12/31/2999 |
| Q4082 | DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2007 | 12/31/2999 |
| Q4100 | SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4101 | APLIGRAF, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4102 | OASIS WOUND MATRIX, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |

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| Q4103 | OASIS BURN MATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4103 | OASIS BURN MATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4104 | INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4104 | INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4105 | Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4106 | DERMAGRAFT, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4107 | GRAFTJACKET, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4108 | INTEGRA MATRIX, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4110 | PRIMATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4110 | PRIMATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4111 | GAMMAGRAFT, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4111 | GAMMAGRAFT, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| Q4112 | CYMETRA, INJECTABLE, 1CC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4112 | CYMETRA, INJECTABLE, 1CC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4113 | GRAFTJACKET XPRESS, INJECTABLE, 1CC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4113 | GRAFTJACKET XPRESS, INJECTABLE, 1CC | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4114 | INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1CC | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4115 | ALLOSKIN, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4115 | ALLOSKIN, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4116 | ALLODERM, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4117 | HYALOMATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4117 | HYALOMATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4118 | MATRISTEM MICROMATRIX, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4118 | MATRISTEM MICROMATRIX, 1 MG | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4121 | THERASKIN, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 6/30/2024 |
| Q4121 | THERASKIN, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 6/30/2024 |
| Q4121 | THERASKIN, PER SQUARE CENTIMETER | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| Q4122 | Dermacell, dermacell awm or dermacell awm porous, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2021 | 12/31/2999 |
| Q4123 | ALLOSKIN RT, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4123 | ALLOSKIN RT, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| Q4124 | OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4124 | OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4125 | ARTHROFLEX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4125 | ARTHROFLEX, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4126 | Memoderm, dermaspan, tranzgraft or integuply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4126 | Memoderm, dermaspan, tranzgraft or integuply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4127 | TALYMED, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4127 | TALYMED, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4128 | Flex hd, or allopatch hd, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2020 | 12/31/2999 |
| Q4130 | STRATTICE TM, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4130 | STRATTICE TM, PER SQUARE CENTIMETER | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4132 | Grafix core and grafixpl core, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4133 | Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |

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| Q4134 | Hmatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4134 | Hmatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4135 | Mediskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4135 | Mediskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4136 | Ez-derm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4136 | Ez-derm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4137 | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4137 | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 7/31/2024 |
| Q4137 | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | 12/31/2999 |
| Q4138 | Biodfence dryflex, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| Q4138 | Biodfence dryflex, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4139 | Amniomatrix or biodmatrix, injectable, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4139 | Amniomatrix or biodmatrix, injectable, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4140 | Biodfence, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4140 | Biodfence, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4141 | Alloskin ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4141 | Alloskin ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4142 | Xcm biologic tissue matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4142 | Xcm biologic tissue matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4143 | Repriza, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4143 | Repriza, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4145 | Epifix, injectable, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4145 | Epifix, injectable, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4146 | Tensix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4146 | Tensix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4147 | Architect, architect px, or architect fx, extracellular matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| Q4147 | Architect, architect px, or architect fx, extracellular matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4148 | Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4148 | Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4149 | Excellagen, 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4149 | Excellagen, 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4150 | Allowrap ds or dry, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4150 | Allowrap ds or dry, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4151 | Amnioband or guardian, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4152 | Dermapure, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4152 | Dermapure, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4153 | Dermavest and plurivest, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4153 | Dermavest and plurivest, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4154 | Biovance, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4155 | Neoxflo or clarixflo, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4155 | Neoxflo or clarixflo, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4156 | Neox 100 or clarix 100, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4156 | Neox 100 or clarix 100, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| Q4157 | Revitalon, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4157 | Revitalon, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4158 | Kerecis omega3, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4158 | Kerecis omega3, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4159 | Affinity, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2022 | 12/31/2999 |
| Q4160 | Nushield, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4160 | Nushield, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4161 | Bio-connekt wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4161 | Bio-connekt wound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4162 | Woundex flow, bioskin flow, 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4162 | Woundex flow, bioskin flow, 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4163 | Woundex, bioskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4163 | Woundex, bioskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4164 | Helicoll, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4164 | Helicoll, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4165 | Keramatrix or kerasorb, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4165 | Keramatrix or kerasorb, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| Q4166 | Cytal, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4166 | Cytal, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4167 | Truskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4167 | Truskin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4168 | Amnioband, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4169 | Artacent wound, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4169 | Artacent wound, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4170 | Cygnus, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4170 | Cygnus, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4171 | Interfyl, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4171 | Interfyl, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4173 | Palingen or palingen xplus, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4173 | Palingen or palingen xplus, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4174 | Palingen or promatrx, 0.36 mg per 0.25 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4174 | Palingen or promatrx, 0.36 mg per 0.25 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4175 | Miroderm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |
| Q4175 | Miroderm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2021 | 12/31/2999 |

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| Q4176 | Neopatch or therion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4176 | Neopatch or therion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4177 | Floweramnioflo, 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4177 | Floweramnioflo, 0.1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4178 | Floweramniopatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4178 | Floweramniopatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4179 | Flowerderm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4179 | Flowerderm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4180 | Revita, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4180 | Revita, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4181 | Amnio wound, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4181 | Amnio wound, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4182 | Transcyte, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4182 | Transcyte, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4183 | Surgigraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4183 | Surgigraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| Q4184 | Cellesta or cellesta duo, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4184 | Cellesta or cellesta duo, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4185 | Cellesta flowable amnion (25 mg per cc); per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4185 | Cellesta flowable amnion (25 mg per cc); per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4186 | Epifix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4187 | Epicord, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2021 | 12/31/2999 |
| Q4188 | Amnioarmor, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4188 | Amnioarmor, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4189 | Artacent ac, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4189 | Artacent ac, 1 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4190 | Artacent ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4190 | Artacent ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4191 | Restorigin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4191 | Restorigin, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4192 | Restorigin, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4192 | Restorigin, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4193 | Coll-e-derm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |

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| Q4193 | Coll-e-derm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4194 | Novachor, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4194 | Novachor, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4195 | Puraply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4195 | Puraply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4196 | Puraply am, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4196 | Puraply am, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4197 | Puraply xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4197 | Puraply xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4198 | Genesis amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4198 | Genesis amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4199 | Cygnus matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4199 | Cygnus matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4200 | Skin te, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4200 | Skin te, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4201 | Matrion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| Q4201 | Matrion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4202 | Keroxx (2.5g/cc), 1cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4202 | Keroxx (2.5g/cc), 1cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4203 | Derma-gide, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4203 | Derma-gide, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4204 | Xwrap, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4204 | Xwrap, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4205 | Membrane graft or membrane wrap, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4205 | Membrane graft or membrane wrap, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4206 | Fluid flow or fluid GF, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4206 | Fluid flow or fluid GF, 1 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4208 | Novafix, per square cenitmeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4208 | Novafix, per square cenitmeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4209 | Surgraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4209 | Surgraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4210 | Axolotl graft or axolotl dualgraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 6/30/2024 |

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

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| Q4218 | Surgicord, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4219 | Surgigraft-dual, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4219 | Surgigraft-dual, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4220 | BellaCell HD or Surederm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4220 | BellaCell HD or Surederm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4221 | Amniowrap2, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4221 | Amniowrap2, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4222 | Progenamatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4222 | Progenamatrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 5/15/2021 | 12/31/2999 |
| Q4224 | Human health factor 10 amniotic patch (hhf10-p), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4224 | Human health factor 10 amniotic patch (hhf10-p), per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4225 | Amniobind or dermabind tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4225 | Amniobind or dermabind tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4226 | MyOwn skin, includes harvesting and preparation procedures, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| Q4226 | MyOwn skin, includes harvesting and preparation procedures, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2024 | 12/31/2999 |
| Q4226 | MyOwn skin, includes harvesting and preparation procedures, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 9/30/2024 |
| Q4227 | Amniocore, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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| Q4227 | Amniocore, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4229 | Cogenex amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4229 | Cogenex amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4230 | Cogenex flowable amnion, per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4230 | Cogenex flowable amnion, per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4231 | Corplex p, per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4231 | Corplex p, per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4232 | Corplex, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4232 | Corplex, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4233 | Surfactor or nudyn, per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4233 | Surfactor or nudyn, per 0.5 cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4234 | Xcellerate, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4234 | Xcellerate, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4235 | Amniorepair or altiply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4235 | Amniorepair or altiply, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4236 | Carepatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |

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

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| Q4245 | Amniotext, per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4246 | Coretext or protext, per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4246 | Coretext or protext, per cc | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4247 | Amniotext patch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4247 | Amniotext patch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4248 | Dermacyte amniotic membrane allograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4248 | Dermacyte amniotic membrane allograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| Q4249 | Amniply, for topical use only, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4249 | Amniply, for topical use only, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4250 | Amnioamp-mp, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4250 | Amnioamp-mp, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4251 | Vim, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4251 | Vim, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4252 | Vendaje, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4252 | Vendaje, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4253 | Zenith amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |

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| Q4253 | Zenith amniotic membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/15/2022 | 12/31/2999 |
| Q4254 | Novafix dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4254 | Novafix dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4255 | Reguard, for topical use only, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4255 | Reguard, for topical use only, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 3/1/2021 | 12/31/2999 |
| Q4256 | Mlg-complete, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4256 | Mlg-complete, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4257 | Relese, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4257 | Relese, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4258 | Enverse, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4258 | Enverse, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 8/1/2022 | 12/31/2999 |
| Q4259 | Celera dual layer or celera dual membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4259 | Celera dual layer or celera dual membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4260 | Signature apatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4260 | Signature apatch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4261 | Tag, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |

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| Q4261 | Tag, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4262 | Dual layer impax membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4262 | Dual layer impax membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4263 | Surgraft tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4263 | Surgraft tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4264 | Cocoon membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4264 | Cocoon membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 1/1/2023 | 12/31/2999 |
| Q4265 | Neostim tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4265 | Neostim tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4266 | Neostim membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4266 | Neostim membrane, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4267 | Neostim dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4267 | Neostim dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4268 | Surgraft ft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4268 | Surgraft ft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4269 | Surgraft xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |

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| Q4269 | Surgraft xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4270 | Complete sl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4270 | Complete sl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4271 | Complete ft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4271 | Complete ft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2023 | 12/31/2999 |
| Q4272 | Esano a, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4272 | Esano a, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4273 | Esano aaa, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4273 | Esano aaa, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4274 | Esano ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4274 | Esano ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4275 | Esano aca, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4275 | Esano aca, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4276 | Orion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4276 | Orion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4277 | Woundplus membrane or e-graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 6/30/2024 |

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| Q4277 | Woundplus membrane or e-graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 6/30/2024 |
| Q4278 | Epieffect, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4278 | Epieffect, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4279 | Vendaje ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4279 | Vendaje ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4279 | Vendaje ac, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4280 | Xcell amnio matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4280 | Xcell amnio matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4281 | Barrera sl or barrera dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4281 | Barrera sl or barrera dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4282 | Cygnus dual, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4282 | Cygnus dual, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4283 | Biovance tri-layer or biovance 3l, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/15/2023 | 12/31/2999 |
| Q4284 | Dermabind sl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4284 | Dermabind sl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2023 | 12/31/2999 |
| Q4285 | Nudyn dl or nudyn dl mesh, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| Q4285 | Nudyn dl or nudyn dl mesh, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |

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| Q4286 | Nudyn sl or nudyn slw, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| Q4286 | Nudyn sl or nudyn slw, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 10/1/2023 | 12/31/2999 |
| Q4287 | Dermabind dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4287 | Dermabind dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4287 | Dermabind dl, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4288 | Dermabind ch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4288 | Dermabind ch, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4288 | Dermabind ch, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4289 | Revoshield + amniotic barrier, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4289 | Revoshield + amniotic barrier, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4289 | Revoshield + amniotic barrier, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4290 | Membrane wrap-hydro, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4290 | Membrane wrap-hydro, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4290 | Membrane wrap-hydro, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4291 | Lamellas xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4291 | Lamellas xt, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4291 | Lamellas xt, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4292 | Lamellas, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| Q4292 | Lamellas, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4292 | Lamellas, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4293 | Acesso dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4293 | Acesso dl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4293 | Acesso dl, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4294 | Amnio quad-core, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4294 | Amnio quad-core, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4294 | Amnio quad-core, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4295 | Amnio tri-core amniotic, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4295 | Amnio tri-core amniotic, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4295 | Amnio tri-core amniotic, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4296 | Rebound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4296 | Rebound matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4296 | Rebound matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4297 | Emerge matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4297 | Emerge matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4297 | Emerge matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4298 | Amnicore pro, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| Q4298 | Amnicore pro, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4298 | Amnicore pro, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4299 | Amnicore pro+, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4299 | Amnicore pro+, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4299 | Amnicore pro+, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4300 | Acesso tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4300 | Acesso tl, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4300 | Acesso tl, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4301 | Activate matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4301 | Activate matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4301 | Activate matrix, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4302 | Complete aca, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4302 | Complete aca, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4302 | Complete aca, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4303 | Complete aa, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4303 | Complete aa, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4303 | Complete aa, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 6/30/2024 |
| Q4304 | Grafix plus, per square centimeter | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/15/2024 | 12/31/2999 |
| Q4305 | American amnion ac tri-layer, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |

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| Q4305 | American amnion ac tri-layer, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4306 | American amnion ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4306 | American amnion ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4307 | American amnion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4307 | American amnion, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4308 | Sanopellis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4308 | Sanopellis, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4309 | Via matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4309 | Via matrix, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4310 | Procenta, per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4310 | Procenta, per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 4/1/2024 | 12/31/2999 |
| Q4311 | Acesso, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4311 | Acesso, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4312 | Acesso ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4312 | Acesso ac, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4313 | Dermabind fm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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| Q4313 | Dermabind fm, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4314 | Reeva ft, per square cenitmeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4314 | Reeva ft, per square cenitmeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4315 | Regenelink amniotic membrane allograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4315 | Regenelink amniotic membrane allograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4316 | Amchoplast, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4316 | Amchoplast, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4317 | Vitograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4317 | Vitograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4318 | E-graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4318 | E-graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4319 | Sanograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4319 | Sanograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4320 | Pellograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4320 | Pellograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4321 | Renograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |

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

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| Q4329 | Singlay, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4330 | Total, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4330 | Total, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4331 | Axolotl graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4331 | Axolotl graft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4332 | Axolotl dualgraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4332 | Axolotl dualgraft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4333 | Ardeograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q4333 | Ardeograft, per square centimeter | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 7/1/2024 | 12/31/2999 |
| Q5106 | Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/15/2020 | 12/31/2999 |
| Q5109 | Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2020 | 12/31/2999 |
| Q5124 | Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2022 | 12/31/2999 |
| Q5128 | Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 6/1/2023 | 12/31/2999 |
| Q5133 | Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 8/1/2024 | 12/31/2999 |
| Q5134 | Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/1/2024 | 12/31/2999 |
| Q5138 | Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 7/15/2024 | 12/31/2999 |
| S0013 | Esketamine, nasal spray, 1 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2021 | 12/31/2999 |
| S0117 | Tretinoin, topical, 5 grams | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S0142 | COLISTIMETHATE SODIUM, INHALATION SOLUTION ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MG | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2005 | 12/31/2999 |
| S0155 | Sterile dilutant for epoprostenol, 50ml | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| S0157 | Becaplermin gel 0. 01%, 0. 5 gm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2006 | 12/31/2999 |
| S0189 | Testosterone pellet, 75mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2010 | 3/14/2024 |
| S0197 | PRENATAL VITAMINS, 30-DAY SUPPLY | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 4/1/2005 | 12/31/2999 |
| S0207 | Paramedic intercept, non-hospital-based als service (non-voluntary), non-transport | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S0209 | Wheelchair van, mileage, per mile | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| S0215 | Non-emergency transportation; mileage, per mile | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| S0320 | Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S0596 | PHAKIC INTRAOCULAR LENS FOR CORRECTION OF REFRACTIVE ERROR | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2012 | 12/31/2999 |
| S0800 | Laser in situ keratomileusis (lasik) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 11/1/2011 | 12/31/2999 |
| S0810 | Photorefractive keratectomy (prk) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| S2080 | Laser-assisted uvulopalatoplasty (laup) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/1/2020 | 12/31/2999 |
| S2102 | Islet cell tissue transplant from pancreas; allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/15/2023 | 12/31/2999 |
| S2103 | Adrenal tissue transplant to brain | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| S2112 | Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/1/2022 | 12/31/2999 |
| S2117 | Arthroereisis, subtalar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S2117 | Arthroereisis, subtalar | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S2118 | Metal-on-metal total hip resurfacing, including acetabular and femoral components | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2008 | 12/31/2999 |
| S2140 | Cord blood harvesting for transplantation, allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2013 | 12/31/2999 |
| S2142 | Cord blood-derived stem-cell transplantation, allogeneic | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 2/1/2013 | 12/31/2999 |
| S2150 | Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |

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| S2202 | Echosclerotherapy | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| S2230 | Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| S2300 | Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S2300 | Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S2400 | Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| S2401 | Repair, urinary tract obstruction in the fetus, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| S2402 | Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| S2403 | Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2012 | 12/31/2999 |
| S2404 | Repair, myelomeningocele in the fetus, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| S2405 | Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2012 | 12/31/2999 |
| S2409 | Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/1/2023 | 12/31/2999 |
| S2411 | Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 12/1/2022 | 12/31/2999 |
| S3600 | Stat laboratory request (situations other than s3601) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S3601 | Emergency stat laboratory charge for patient who is homebound or residing in a nursing facility | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S3650 | Saliva test, hormone level; during menopause | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S3650 | Saliva test, hormone level; during menopause | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S3652 | Saliva test, hormone level; to assess preterm labor risk | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S3652 | Saliva test, hormone level; to assess preterm labor risk | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S3900 | Surface electromyography (emg) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| S3900 | Surface electromyography (emg) | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| S4026 | Procurement of donor sperm from sperm bank | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| S4027 | Storage of previously frozen embryos | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4030 | Sperm procurement and cryopreservation services; initial visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4031 | Sperm procurement and cryopreservation services; subsequent visit | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4040 | Monitoring and storage of cryopreserved embryos, per 30 days | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4990 | Nicotine patches, legend | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4991 | Nicotine patches, non-legend | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S4995 | Smoking cessation gum | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5100 | Day care services, adult; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5101 | Day care services, adult; per half day | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5102 | Day care services, adult; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5105 | Day care services, center-based; services not included in program fee, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5108 | Home care training to home care client, per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5109 | Home care training to home care client, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5110 | Home care training, family; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5111 | Home care training, family; per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5115 | Home care training, non-family; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5116 | Home care training, non-family; per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5120 | Chore services; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5121 | Chore services; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5125 | Attendant care services; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5126 | Attendant care services; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5130 | Homemaker service, nos; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5131 | Homemaker service, nos; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5135 | Companion care, adult (e. G. Iadl/adl); per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5136 | Companion care, adult (e. G. Iadl/adl); per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| S5140 | Foster care, adult; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5141 | Foster care, adult; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5145 | Foster care, therapeutic, child; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5146 | Foster care, therapeutic, child; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5150 | Unskilled respite care, not hospice; per 15 minutes | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5151 | Unskilled respite care, not hospice; per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5160 | Emergency response system; installation and testing | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5161 | Emergency response system; service fee, per month (excludes installation and testing) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5162 | Emergency response system; purchase only | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5165 | Home modifications; per service | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5170 | Home delivered meals, including preparation; per meal | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5175 | Laundry service, external, professional; per order | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5185 | Medication reminder service, non-face-to-face; per month | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S5199 | Personal care item, nos, each | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S8035 | Magnetic source imaging | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2009 | 12/31/2999 |
| S8040 | Topographic brain mapping | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 3/1/2024 | 12/31/2999 |
| S8130 | INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S8130 | INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S8131 | INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 11/1/2016 | 12/31/2999 |
| S8131 | INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 11/1/2016 | 12/31/2999 |
| S8270 | Enuresis alarm, using auditory buzzer and/or vibration device | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 7/1/2005 | 12/31/2999 |
| S8415 | Supplies for home delivery of infant | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S8460 | Camisole, post-mastectomy | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| S8930 | ELECTRICAL STIMULATION OF AURICULAR ACUPUNCTURE POINTS; EACH 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| S8940 | EQUESTRIAN/HIPPOTHERAPY, PER SESSION | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S8940 | EQUESTRIAN/HIPPOTHERAPY, PER SESSION | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S8948 | Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 9/24/2012 | 12/31/2999 |
| S9001 | Home uterine monitor with or without associated nursing services | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S9001 | Home uterine monitor with or without associated nursing services | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 9/1/2020 | 12/31/2999 |
| S9002 | Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 4/1/2024 | 12/31/2999 |
| S9055 | Procuren or other growth factor preparation to promote wound healing | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 11/1/2019 | 12/31/2999 |
| S9056 | Coma stimulation per diem | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S9056 | Coma stimulation per diem | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/1/2020 | 12/31/2999 |
| S9090 | Vertebral axial decompression, per session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| S9090 | Vertebral axial decompression, per session | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP). | 12/15/2014 | 12/31/2999 |
| S9117 | Back school, per visit | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2022 | 12/31/2999 |
| S9122 | Home health aide or certified nurse assistant, providing care in the home; per hour | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9125 | Respite care, in the home, per diem | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9436 | Childbirth preparation/lamaze classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9437 | Childbirth refresher classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9438 | Cesarean birth classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9439 | Vbac (vaginal birth after cesarean) classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9444 | Parenting classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| S9447 | Infant safety (including cpr) classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9449 | Weight management classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9451 | Exercise classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9454 | Stress management classes, non-physician provider, per session | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9482 | FAMILY STABILIZATION SERVICES, PER 15 MINUTES | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2005 | 12/31/2999 |
| S9558 | Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| S9560 | 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 | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| S9900 | SERVICES BY A JOURNAL-LISTED CHRISTIAN SCIENCE PRACTITIONER FOR THE PURPOSE OF HEALING, PER DIEM | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9960 | Ambulance service, conventional air services, nonemergency transport, one way (fixed wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| S9961 | Ambulance service, conventional air service, nonemergency transport, one way (rotary wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/2014 | 12/31/2999 |
| S9961 | Ambulance service, conventional air service, nonemergency transport, one way (rotary wing) | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. This code is managed by Alacura. | 1/1/2025 | 12/31/2999 |
| S9970 | Health club membership, annual | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9976 | Lodging, per diem, not otherwise classified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9977 | Meals, per diem, not otherwise specified | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9981 | Medical records copying fee, administrative | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9982 | Medical records copying fee, per page | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9986 | Not medically necessary service (patient is aware that service not medically necessary) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9988 | Services provided as part of a phase i clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9989 | Services provided outside of the united states of america (list in addition to code(s) for services(s)) | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9990 | Services provided as part of a phase ii clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9991 | Services provided as part of a phase iii clinical trial | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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| S9992 | Transportation costs to and from trial location and local transportation costs (e. G. , fares for taxicab or bus) for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9994 | Lodging costs (e. G. , hotel charges) for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9996 | Meals for clinical trial participant and one caregiver/companion | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| S9999 | Sales tax | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2025 | Deluxe frame | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| V2219 | Bifocal seg width over 28mm | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2600 | Hand held low vision aids and other nonspectacle mounted aids | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2610 | Single lens spectacle mounted low vision aids | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2615 | Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2627 | Scleral cover shell | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 5/15/2016 | 12/31/2999 |
| V2702 | DELUXE LENS FEATURE | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/2021 | 12/31/2999 |
| V2715 | Prism, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2718 | Press-on lens, fresnell prism, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2730 | Special base curve, glass or plastic, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2744 | Tint, photochromatic, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2750 | Anti-reflective coating, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2755 | U-v lens, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2760 | Scratch resistant coating, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2770 | Occluder lens, per lens | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V2787 | ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2008 | 12/31/2999 |
| V2788 | PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 10/15/2008 | 12/31/2999 |
| V2799 | Vision item or service, miscellaneous | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |
| V5095 | Semi-implantable middle ear hearing prosthesis | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review to avoid post-service review. | 1/1/1950 | 12/31/2999 |
| V5364 | Dysphagia screening | Non Covered: Procedure/service not covered by the Plan. Not subject to pre-service review. | 1/1/1950 | 12/31/2999 |

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

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

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Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors.